EXHIBIT 4

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

MARISSA COLLINS, on her own behalf, and on behalf of all others similarly situated, and JAMES BURNETT, on behalf of his son, and on behalf of all others similarly situated,

Plaintiffs,

vs.

ANTHEM, INC. and ANTHEM UM SERVICES, INC.,

Defendants.

Civil Action No. 2:20-cv-01969-FB-SIL

VIDEO-RECORDED DEPOSITION OF WITNESS, KEITH ISENBERG, MD, produced, sworn and examined on the 15th day of June, 2022, between the hours of eight o'clock in the forenoon and six o'clock in the afternoon of that day, via Veritext Virtual videoconference, before Tara Schwake, a Registered Professional Reporter, Certified Realtime Reporter, Certified Shorthand Reporter (IL), Certified Court Reporter (MO), and Notary Public within and for the State of Missouri.

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JEFF GIBBS, Concierge

needed to develop and review BH UM guidelines.
MCG has a process for doing that that's -- that, as described, is -- was judged to be equivalent to the work that Anthem was allocating to the same -- for the same purpose.
Q Is there any -- any subgroup or body with behavioral health expertise within Anthem that is now responsible for oversight of the MCGs?
A It is the responsibility of the Medical Policy & Technology Assessment Committee to make decisions about accepting or rejecting MCG guidelines.
Q Um, what --
A The clinical content of the guidelines. I should be specific.
Q Does, um, does Anthem customize the MCG guidelines in certain respects? That's just a general -- a general -- a general first question. Do they -- do they customize them?
A Yes.
Q In the area of Behavioral Health level of care guidelines, has Anthem customized the MCGs?
A Not in the area of level of care guidelines.

again if you want.

Q No, I'm just trying to understand if there was a document or if they were -- those characteristics, as you've described, were compiled somewhere or -- or written down.

A Not that I'm aware of.

Q When did Anthem begin the process of considering the MCG level of care guidelines as a potential replacement for CG-BEH-03?

A I'm not sure of the precise -- precise date but I think it was roughly a year or 18 months prior to their adoption. Something like that.

Q What prompted the consideration of MCG?

A The medical-surgical teams used MCG. So given that circumstances -- given that circumstance, um, why didn't BH use MCG also. That creates a type of internal consistency.

Q Were there -- were there other non-MCG guidelines used on the med-surg side?

A Um, so, um, there are Anthem medical policies and UM guidelines, there -- which sometimes result in customization of the MCG guidelines, and, therefore, you basically then have

Did -- did you say that on the med-surg side Anthem was already using MCG guidelines for a number of -- for a number of services?

A For most utiliz -- for most medical-surgical utilization purposes.

Q Do you know when, um, Anthem had begun its -- had -- had begun its relationship with MCG?

A That's a good question. I believe they had a relationship with MCG when I joined the company 15 years ago. But I'm not entirely sure of that.

Q Do you recall where -- where in Anthem -- strike the question.

Where in Anthem did the initiative to consider the MCG guidelines for behavioral health begin?

A Um, it was a group discussion. So um, lots of people participated in the discussion. There were a variety of opinions, and so just starting the discussion, it's not the -- it's not the critical piece. The critical piece is, okay, well, if you do -- if you decide you're going to give consideration to MCG or any other set of

guidelines, what does that mean clinically?

So what are you using now and what will happen clinically when you use MCG guidelines. What's your best guess.

And so you -- you -- the real important aspect of the work is not the decision that maybe we ought to look at MCG for these reasons. The real important part of the decision is, well, what does it mean for clinical care?

And you would have -- we did give some consideration to other types of guidelines. The observation was that, um, the switch to MCG appeared to be the less disruptive of -- of -- of clinical decision-making.

Q And when you say "less disruptive," you mean internally because -- internally within the -- within the Anthem operations for its -- its daily work reviewing claim requests?

A It would -- it would also apply to the provider community, meaning that if we make the change, can we -- if I'm talking to a doctor and they say to me, well, you know, six months ago it was CG-BEH-03 and now it's -- it's this MCG thing, how are they any different? And the answer would be, well, they're not really all that much

different.

And, well, then, Dr. Isenberg, how do you know that? Well, because we looked into that and we couldn't find any -- we couldn't find any differences that we thought would make it -- make a -- have a substantial impact on the way we operated.

And, um, if -- if the doctor said back to me, well, I disagree, they would have been given information about how to, um, to express their disagreement so that we could take that into consideration as we moved forward.

Q When you say the conver -- the initial conversation involved a lot of people, what areas of Anthem were involved in that first -- in those -- those early discussions?

A Medical management, the UM operations folks. You have to -- you'll have -- you would know that there would have to be some sort of training exercise. Contracting because you'll have to -- there will be some costs associated with these changes, costs associated with new contracting if nothing else.

Legal, does this increase or decrease or make any difference from a risk perspective,

consideration of whether it will have any impact on our accreditation, consideration of whether it might have some impact on our UM licenses.

Those are the ones I can think of. I think there were other, probably other parties involved in the discussions.

Q And what, um, you said sort of there was consideration of what the clinical impact would be. Of the switch to guidelines; yes?

A That's correct.

Q How was that done?

A So there was a crosswalk created to try to identify differences between MCG and CG-BEH-03. The other -- the other guidelines as well. And evaluation of the crosswalks suggested that it wouldn't make much difference clinically.

Q And who created the crosswalks?

A I don't -- I don't remember -- I was involved but I don't remember who was responsible. I think it was the Office of Medical Policy & Technology Assessment, if I remember correctly.

Q But -- but created internally at Anthem?

A It was created internally at Anthem, that's correct.

EXHIBIT 5

Anthem

Medical Policy

Subject: Medical Policy Formation
Document #: ADMIN.00001H
Status: Revised (Historic as of 12/27/2017)
Current Effective Date: 03/29/2017
Last Review Date: 02/02/2017

Description/Scope

The Office of Medical Policy & Technology Assessment (OMPTA) develops medical policy and clinical UM guidelines (collectively, "Medical Policy") for the company. The principal component of the process is the review for development of medical necessity and/or investigational policy position statements or clinical indications for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services include, but are not limited to devices, biologics and specialty pharmaceuticals, and behavioral health services.

Medical Policies are intended to reflect the current scientific data and clinical thinking. While Medical Policy sets forth position statements or clinical indications regarding the medical necessity of individual services and/or procedures, Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

The Medical Policy & Technology Assessment Committee (MPTAC) is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. Voting membership includes:

- External physicians in clinical practices and participating in networks;
- External physicians in academic practices and participating in networks;
- Internal medical directors;
- Chairs of MPTAC Subcommittees.

Non-voting members include:

- Internal legal counsel.

MPTAC meets at least three times per year. Agenda topics are identified, researched, updated, collated and distributed to the committee. Input from the medical community is solicited and utilized in developing and updating policies. In addition, agenda items are identified from, but not limited to: clinical literature, medical operations associates, medical directors, claims operations, external reviews, technology vendors, and other technology assessment entities. Decisions are made by a majority vote of MPTAC voting members present. Majority representation of the voting committee members must be present to constitute a quorum. MPTAC has designated subcommittees for certain specialty topics, such as hematology/oncology (Hem/Onc) and behavioral health (BH). Subcommittees are composed of specialists in related fields (for example, Hem/Onc includes hematologists, medical oncologists and radiation oncologists, and BH includes BH practitioners) and may include external physicians that are

not members of MPTAC, but are in clinical or academic practices and are participating in networks. The subcommittees shall make recommendations to MPTAC on topics assigned to them by MPTAC.

MPTAC voting members and subcommittee members are required to disclose any potential conflicts of interest. In the event that a MPTAC voting member or subcommittee member discloses a conflict of interest, the associated member will not participate in the vote specific to the proposed relevant Medical Policy.

To reach decisions regarding the medical necessity or investigational status of new or existing services and/or procedures, MPTAC (and its applicable subcommittees) relies on the medical necessity or investigational criteria included in the following policies:

- ADMIN.00004 Medical Necessity Criteria
- ADMIN.00005 Investigational Criteria

In evaluating the medical necessity or investigational status of new or existing services and/or procedures the committee(s) may include, but not limit their consideration to, the following additional information:

- electronic literature searches, which are conducted and collated results are provided to the committee members;
- independent technology evaluation programs and materials published by professional associations, such as:
  - Blue Cross Blue Shield Association (BCBSA);
  - Technology assessment entities;
  - Appropriate government regulatory bodies; and
  - National physician specialty societies and associations.

The committee(s) may also consider the service/procedure being reviewed as a standard of care in the medical community with supporting documentation.

The committee(s) is also responsible for reviewing and authorizing the use of Medical Policy used in making determinations of medical necessity or investigational determinations which are developed by external entities (for example, MCG care guidelines or InterQual® criteria).

Additionally, for topics deemed to represent a significant change or as otherwise required by law or accreditation, the medical policy team seeks additional input from selected experienced clinicians. This process allows MPTAC access to the expertise of a wide variety of specialists and subspecialists from across the United States. These individuals are board certified providers who are identified either with the assistance of an appropriate professional medical specialty society, by activity in a participating academic medical center or by participation in a corporate affiliated network. While the various professional medical societies may collaborate in this process through the provision of appropriate reviewers, the input received represents NEITHER an endorsement by the specialty society NOR an official position of the specialty society. MPTAC uses this information in the context of all other information presented from various sources.

A Medical Policy may be developed and approved between scheduled MPTAC meetings, if in the opinion of the Vice President of OMPTA or designee, there is an urgent need to establish a new Medical Policy, or revise an existing policy, prior to the next scheduled meeting of MPTAC. The research associates of OMPTA will develop the draft Medical Policy and request input from appropriate consultant providers, and if applicable, the relevant subcommittee. An ad-hoc interim Medical Policy meeting or vote is scheduled to review and vote on the proposed interim Medical Policy. Any policy presented on an interim basis (whether approved, modified or rejected) will be presented for full review and discussion at the next scheduled MPTAC meeting.

In the absence of specific Medical Policy, case-by-case individual review is undertaken. A physician designated by the health plan, will review the request using the technology assessment criteria and appropriate standards that may include, but are not limited to, any of the following: peer-reviewed literature, other organizations' technology evaluations including the BCBSA, Agency for Healthcare Research and Quality (AHRQ), various medical specialty societies' guidelines and assessments and the clinician's professional judgment. Refer to the following policy for additional information: ADMIN.00006 Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline.

All existing Medical Policies are reviewed at least annually through MPTAC to determine continued applicability, appropriateness, and whether there is a need for revision, updates to citations, or other changes.

Medical Policies approved by MPTAC are also communicated throughout the company for inclusion in the benefit plan and for implementation of supporting processes. These communication processes include:

- Attendance of key associates at MPTAC meetings;
- Teleconferences with and written documentation to medical operations associates, medical directors, claims and network relations associates;
- Provision of MPTAC meeting minutes and other relevant documentation to health plan leadership.

Medical Policy decisions affecting our members are reported by our health plans to and reviewed for input by the appropriate physician quality committees, which have the responsibility for reviewing MPTAC activities.

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Medical Policy & Technology Assessment Committee
MPTAC
Office of Medical Policy & Technology Assessment
OMPTA

Document History

Status	Date	Action
Historic	12/27/2017	Not to be used for dates of service on or after 12/27/2017.

Revised	02/02/2017	Medical Policy & Technology Assessment Committee (MPTAC) review. Minor typographical revisions made to the Description section.
Reviewed	02/04/2016	MPTAC review.
Revised	02/05/2015	MPTAC review. Clarifications to the Description/Scope section.
Revised	02/13/2014	MPTAC review. Updated Description/Scope concerning MPTAC voting membership and specialist/practitioner involvement in the MPTAC decision-making process.
Revised	08/08/2013	MPTAC review. Updates to the Description/Scope to include a statement addressing committee(s) responsibility for reviewing and authorizing the use of Medical Policy. Additional format revisions and clarifications throughout the document.
Revised	08/09/2012	MPTAC review. Clarifications to the Description section with reference to ADMIN.00004 and ADMIN.00005.
Revised	11/17/2011	MPTAC review. Clarified names of specific departments within the organization. Revised wording throughout the document including the annual review process statement.
Revised	11/18/2010	MPTAC review. Addition of acronyms for specific organizations including the Office of Medical Policy & Technology Assessment (OMPTA) to the Description/Scope and Index. Revised title for ADMIN.00006 to Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline.
Reviewed	11/19/2009	MPTAC review.
Reviewed	11/20/2008	MPTAC review. Removed the word experimental from the Description/Scope statement.
Revised	11/29/2007	MPTAC review. Addition of reference to subcommittees.
Revised	12/07/2006	MPTAC review. Clarification to wording and removal of procedural information.
Revised	12/01/2005	MPTAC review. Reference to ADMIN.00006 added; deleted Hayes, Inc. as reference when there is no medical policy or clinical guideline available.
Revised	09/22/2005	MPTAC review. 1. Included statement regarding MPTAC voting member's requirement to disclose potential conflicts of interest and the reclusion of their associated vote on the relevant medical policy where a conflict of interest has been disclosed. 2. Modified wording specific to the section beginning "In the absence of specific medical policy..." to align with the Settlement Agreement requirements on Initial Determinations (7.14 a).
Reviewed	07/14/2005	MPTAC review. Revision based on Pre-merger Anthem and Pre-merger WellPoint Harmonization.

Pre-Merger Organizations	Last Review Date	Title

		Document Number	
Anthem, Inc.		No prior document	
WellPoint Health Networks, Inc.	09/23/2004		Medical Policy and Technology Assessment – Policy Formation

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

EXHIBIT 6

Anthem

Medical Policy

Subject:	Medical Policy Formation		
Policy #:	ADMIN.00001	**Publish Date:**	12/16/2020
Status:	Revised	**Last Review Date:**	11/05/2020

Description/Scope

The Office of Medical Policy & Technology Assessment (OMPTA) develops medical policy and clinical UM guidelines (collectively, "Medical Policy") for the company. The principal component of the process is the review for development of medical necessity and/or investigational position statements or clinical indications that are objective and based on medical evidence for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services consisting of medical, surgical, and behavioral health treatments, may include, but are not limited to devices, biologics, specialty pharmaceuticals, gene therapies, and professional health services.

Medical Policies are intended to reflect current scientific data and clinical thinking. While Medical Policy sets forth position statements or clinical indications regarding the medical necessity of individual services and/or procedures, Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

The Medical Policy & Technology Assessment Committee (MPTAC) is a multiple disciplinary group including physicians from various medical and behavioral health specialties, clinical practice environments and geographic areas. Voting membership may include:

- External physicians in clinical practices and participating in networks;
- External physicians in academic practices and participating in networks;
- Internal medical directors;
- Chairs of MPTAC Subcommittees.

Non-voting members may include:

- Internal legal counsel;
- Internal medical directors.

MPTAC meets at least three times per year. Agenda topics are identified, researched, updated, collated and distributed to the committee. Input from the medical community is solicited and utilized in developing and updating criteria. In addition, agenda items are identified from, but not limited to: clinical literature, medical operations associates, medical directors, claims operations, external reviews, technology vendors, and other technology assessment entities. Decisions are made by a majority vote of MPTAC voting members present. Majority representation of the voting committee members must be present to constitute a quorum. MPTAC may designate subcommittees when needed, which may include internal or external physicians. The subcommittees shall make recommendations to MPTAC on topics assigned to them by MPTAC.

MPTAC voting members and subcommittee members are required to disclose any potential conflicts of interest. In the event that a MPTAC voting member or subcommittee member discloses a conflict of interest, the associated member will not participate in the vote specific to the proposed relevant Medical Policy.

To reach decisions regarding the medical necessity or investigational status of new or existing services and/or procedures, MPTAC (and its applicable subcommittees) relies on the medical necessity or investigational criteria included in the following policies:

- ADMIN.00004 Medical Necessity Criteria
- ADMIN.00005 Investigational Criteria

In evaluating the medical necessity or investigational status of new or existing services and/or procedures the committee(s) may include, but not limit their consideration to, the following additional information provided to committee members:

- Collated results of electronic literature searches;
- Independent technology evaluation programs and materials published by professional associations, such as:
  - Technology assessment entities;
  - Appropriate government regulatory bodies; and
  - National physician specialty societies and associations.

When reviewing the results of electronic literature searches, the committee may consider study methodology, including but not limited to features such as randomization, blinding, clinically appropriate follow-up periods, and use of validated and objective measurements tools. The committee will also consider whether studies provide credible scientific evidence which permits reasonable conclusions regarding net health outcomes (balance of safety and efficacy) and appropriate comparisons to established alternatives. The literature discussed and included in policy documents should not be construed to represent all of the scientific evidence available on a topic or reviewed in policy development. Publications such as review articles, white papers, case studies, abstracts, and articles not published in medical journals indexed in the National Library of Medicine's PubMed database are typically not included in policy documents.

The committee(s) may also consider the service/procedure being reviewed as a standard of care in the medical community with supporting documentation.

The committee(s) is also responsible for reviewing and authorizing the use of Medical Policy used in making determinations of medical necessity which are developed by external entities (for example, MCG care guidelines or InterQual® criteria).

Additionally, for topics deemed to represent a significant change or as otherwise required by law or accreditation, the OMPTA team seeks additional input from selected experienced clinicians. This process allows MPTAC access to the expertise of a wide variety of specialists and subspecialists from across the United States. These individuals are board certified providers who are identified either with the assistance of an appropriate professional medical specialty society, by activity in a participating academic medical center or by participation in a corporate affiliated network. While the various professional medical societies may collaborate in this process through the provision of appropriate reviewers, the input received represents NEITHER an endorsement by the specialty society NOR an official position of the specialty society. MPTAC uses this information in the context of all other information presented from various sources.

Medical Policy may be developed and approved or revised between scheduled MPTAC meetings, when there is a need to do so prior to the next scheduled meeting of MPTAC. The research associates of OMPTA will develop the draft Medical Policy and request input from appropriate consultant providers, and if applicable, the relevant subcommittee. An ad-hoc interim MPTAC meeting or vote is scheduled to review and vote on the proposed interim Medical Policy. Policies presented on an interim basis (whether approved, modified or rejected) may be presented for full review and discussion at the next scheduled MPTAC meeting when additional committee input is required (for example, additional clinical input is received).

In the absence of specific Medical Policy, case-by-case individual review is undertaken. A physician designated by the health plan will review the request using the technology assessment criteria and appropriate standards that may include, but are not limited to, any of the following: peer-reviewed literature, other organizations' technology evaluations, Agency for Healthcare Research and Quality (AHRQ), various medical specialty societies' guidelines and assessments, and the clinician's professional judgment. Refer to the following document for additional information: ADMIN.00006 Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline.

All existing Medical Policies are reviewed at least annually through MPTAC to determine continued applicability, appropriateness, and whether there is a need for revision, updates to citations, or other changes.

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- Provision of MPTAC meeting minutes and other relevant documentation to health plan leadership.

Medical Policy decisions affecting our members are reported by our health plans to and reviewed for input by the appropriate physician quality committees, which have the responsibility for reviewing MPTAC activities.

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Document History

Status	Date	Action
Revised	11/05/2020	Medical Policy & Technology Assessment Committee (MPTAC) review. Added text in Scope section regarding evidence review process.
Reviewed	08/13/2020	MPTAC review.
Revised	11/07/2019	MPTAC review. Updated text in Scope regarding services addressed and

		subspecialty committees.
Revised	11/08/2018	MPTAC review. Updated Description/Scope section concerning MPTAC membership to include BH specialists. Updated text regarding subspecialty committees, including removal of BH subcommittee. Clarified TPC subcommittee may include BH specialists. Updated Index section.
Revised	01/25/2018	MPTAC review. Updated Description/Scope concerning MPTAC and subspecialty committee voting membership, clarified that non-voting members may include internal medical directors, added details regarding third party criteria subcommittee, and revised text related to topics brought to interim meetings.
Revised	11/02/2017	MPTAC review. The document header wording updated from "Current Effective Date" to "Publish Date." Clarification made in the Description/Scope section.
Revised	02/02/2017	MPTAC review. Minor typographical revisions made to the Description section.
Reviewed	02/04/2016	MPTAC review.
Revised	02/05/2015	MPTAC review. Clarifications to the Description/Scope section.
Revised	02/13/2014	MPTAC review. Updated Description/Scope concerning MPTAC voting membership and specialist/practitioner involvement in the MPTAC decision-making process.
Revised	08/08/2013	MPTAC review. Updates to the Description/Scope to include a statement addressing committee(s) responsibility for reviewing and authorizing the use of Medical Policy. Additional format revisions and clarifications throughout the document.
Revised	08/09/2012	MPTAC review. Clarifications to the Description section with reference to ADMIN.00004 and ADMIN.00005.
Revised	11/17/2011	MPTAC review. Clarified names of specific departments within the organization. Revised wording throughout the document including the annual review process statement.
Revised	11/18/2010	MPTAC review. Addition of acronyms for specific organizations including the Office of Medical Policy & Technology Assessment (OMPTA) to the Description/Scope and Index. Revised title for ADMIN.00006 to Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline.
Reviewed	11/19/2009	MPTAC review.
Reviewed	11/20/2008	MPTAC review. Removed the word experimental from the Description/Scope statement.
Revised	11/29/2007	MPTAC review. Addition of reference to subcommittees.
Revised	12/07/2006	MPTAC review. Clarification to wording and removal of procedural information.
Revised	12/01/2005	MPTAC review. Reference to ADMIN.00006 added; deleted Hayes, Inc. as reference when there is no medical policy or clinical guideline available.
Revised	09/22/2005	MPTAC review. 1. Included statement regarding MPTAC voting member's requirement to disclose potential conflicts of interest and the reclusion of their associated

		vote on the relevant medical policy where a conflict of interest has been disclosed. 2. Modified wording specific to the section beginning "In the absence of specific medical policy…" to align with the Settlement Agreement requirements on Initial Determinations (7.14 a).
Reviewed	07/14/2005	MPTAC review. Revision based on Pre-merger Anthem and Pre-merger WellPoint Harmonization.

Pre-Merger Organizations	Last Review Date	Document Number	Title
Anthem, Inc.		No prior document	
WellPoint Health Networks, Inc.	09/23/2004		Medical Policy and Technology Assessment – Policy Formation

EXHIBIT 7

Anthem

Medical Policy

Subject: Medical Necessity Criteria
Document #: ADMIN.00004H
Status: Reviewed (Historic as of 09/27/2017)
Current Effective Date: 10/04/2016
Last Review Date: 08/04/2016

THESE CRITERIA ARE USED IN THE DEVELOPMENT AND UPDATING OF MEDICAL POLICIES AND CLINICAL UM GUIDELINES. AS THESE CRITERIA MAY NOT BE THE CRITERIA USED IN THE DEFINITION OF MEDICAL NECESSITY WITHIN THE COVERED INDIVIDUAL'S PLAN DOCUMENT, THE DEFINITION IN THE COVERED INDIVIDUAL'S PLAN DOCUMENT IS TO BE USED FOR BENEFIT DETERMINATIONS. (SEE COVERED INDIVIDUAL'S BENEFIT PLAN FOR SPECIFIC CONTRACT LANGUAGE.)

Definitions

"Medically Necessary" services are procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; **and**
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; **and**
- not primarily for the convenience of the covered individual, physician or other health care provider; **and**
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

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Document History

Status	Date	Action

Historic	09/27/2017	Not to be used for dates of service on or after 09/27/2017.
Reviewed	08/04/2016	Medical Policy & Technology Assessment Committee (MPTAC) review.
Reviewed	08/06/2015	MPTAC review.
Revised	08/14/2014	MPTAC review. Clarification to header.
Reviewed	08/08/2013	MPTAC review.
Reviewed	08/09/2012	MPTAC review.
Revised	08/18/2011	MPTAC review. Clarification to header.
Reviewed	08/19/2010	MPTAC review. Changed title to Medical Necessity Criteria. Index updated.
	05/27/2010	Clarification to header.
Revised	08/27/2009	MPTAC review.
Reviewed	11/20/2008	MPTAC review.
Reviewed	11/29/2007	MPTAC review.
Reviewed	12/07/2006	MPTAC review. No change to position.
Revised	12/01/2005	MPTAC review.

Pre-Merger Organizations	Last Review Date	Document Number	Title
Anthem, Inc.	N/A	N/A	Definition: Medically Necessary or Medical Necessity
WellPoint Health Networks, Inc.	09/22/2005	Definitions ii	Definition: Medically Necessary

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

EXHIBIT 8

Anthem

Medical Policy

Subject:	Medical Necessity Criteria		
Document #:	ADMIN.00004	**Publish Date:**	07/08/2020
Status:	Reviewed	**Last Review Date:**	05/14/2020

THESE CRITERIA ARE USED IN THE DEVELOPMENT AND UPDATING OF MEDICAL POLICIES AND CLINICAL UM GUIDELINES. AS THESE CRITERIA MAY NOT BE THE CRITERIA USED IN THE DEFINITION OF MEDICAL NECESSITY WITHIN THE COVERED INDIVIDUAL'S PLAN DOCUMENT, THE DEFINITION IN THE COVERED INDIVIDUAL'S PLAN DOCUMENT IS TO BE USED FOR BENEFIT DETERMINATIONS (SEE COVERED INDIVIDUAL'S BENEFIT PLAN FOR SPECIFIC CONTRACT LANGUAGE).

Definitions

"Medically Necessary" services are procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; **and**
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; **and**
- not primarily for the convenience of the covered individual, physician or other health care provider; **and**
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

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Document History

Status	Date	Action
Reviewed	05/14/2020	Medical Policy & Technology Assessment Committee (MPTAC) review.
Reviewed	06/06/2019	MPTAC review.
Reviewed	07/26/2018	MPTAC review. The document header wording updated from "Current

		Effective Date" to "Publish Date."
Reviewed	08/03/2017	MPTAC review.
Reviewed	08/04/2016	MPTAC review.
Reviewed	08/06/2015	MPTAC review.
Revised	08/14/2014	MPTAC review. Clarification to header.
Reviewed	08/08/2013	MPTAC review.
Reviewed	08/09/2012	MPTAC review.
Revised	08/18/2011	MPTAC review. Clarification to header.
Reviewed	08/19/2010	MPTAC review. Changed title to Medical Necessity Criteria. Index updated.
	05/27/2010	Clarification to header.
Revised	08/27/2009	MPTAC review.
Reviewed	11/20/2008	MPTAC review.
Reviewed	11/29/2007	MPTAC review.
Reviewed	12/07/2006	MPTAC review. No change to position.
Revised	12/01/2005	MPTAC review.

Pre-Merger Organizations	Last Review Date	Document Number	Title
Anthem, Inc.	N/A	N/A	Definition: Medically Necessary or Medical Necessity
WellPoint Health Networks, Inc.	09/22/2005	Definitions ii	Definition: Medically Necessary

EXHIBIT 9

Anthem UM Services, Inc.

2017 Utilization Management Program Description

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2017
Anthem UM Services, Inc.
Utilization Management Program Description

FOREWORD

Anthem, Inc. designates Anthem UM Services, Inc. (AUMSI), a wholly owned subsidiary, to perform utilization management on behalf of the Companies listed on Appendix B. This document refers to these companies collectively as "Company." Throughout this document, unless otherwise specified, "we" refers to AUMSI.

I. MISSION STATEMENT

Anthem UM Services, Inc. (AUMSI) provides a consistent operational, accreditation, regulatory, and quality improvement framework for the provision of utilization management services across the Companies.

II. PURPOSE

This program description outlines how AUMSI oversees quality improvement activities related to utilization management, supports regulatory and accreditation compliance, and promotes operational consistency while maintaining the flexibility to respond to customer needs. These contributions will help to achieve the purpose statement of Anthem, Inc.

Together, we are transforming health care with trusted and caring solutions

III. GOALS

A. Promote the delivery of medically necessary healthcare services in a cost-effective manner.
B. Perform utilization management services for covered persons in eligible HMO, POS, PPO, EPO, indemnity, Health Insurance marketplace products, commercial group and individual benefit plans and others, as applicable.
C. Promote local coordination of services in collaboration with local business units.
D. Establish, implement, assess and assure that utilization management processes meet the needs and expectations of clients and covered persons.
E. Promote quality of service and effective utilization of service to all clients and covered persons.
F. Monitor and improve, where indicated, access to services when relevant to AUMSI's utilization management (UM) activities.
G. Monitor, analyze and report program performance.
H. Develop and maintain a well-integrated, culturally sensitive system to identify, measure, and improve quality outcomes through standardized and collaborative activities.

I. Maintain compliance with accreditation standards and local, state and federal regulatory requirements.
J. Evaluate the effectiveness of the UM Program and the resources dedicated to it specific to UM.

IV. OBJECTIVES

A. Provide covered persons, health care providers and authorized representatives sufficient access to utilization management associates by toll-free telephone line, electronic (e.g. email, Web, and facsimile), mail/carrier services, or other reasonable means.
B. Establish and maintain processes to obtain and communicate relevant clinical information in order to make the appropriate determination.
C. Establish a consistent process for providing utilization determinations in a timely manner to accommodate the clinical urgency of each situation.
D. Provide health care providers and covered persons with sufficient information to understand both the reasons for an adverse determination and how to initiate an appeal.
E. Promote consistency in the use of clinical guidelines to make utilization and level of care coverage determinations.
F. Establish education and training for all levels of staff.
G. Establish standards of service and access reflecting current national and competitive benchmarks.
H. Establish monitoring programs to investigate trends and/or patterns of UM services.
I. Design and implement activities to improve program performance.
J. Evaluate the impact of trends on satisfaction.
K. Communicate the results of quality improvement related activities to staff, and the AUMSI QIC or other committees, as appropriate.

V. SCOPE OF UM PROGRAM AND PROGRAM OPERATIONS

Utilization Management is a process used to assess the medical necessity, efficiency, and/or appropriateness of health care services in a fair, impartial and consistent manner. UM evaluates the setting of care, and treatment plans in accordance with the definitions contained in the health benefit plan documents. AUMSI encompasses medical, behavioral health and pharmacy services.

Behavioral Health Management

Utilization management for behavioral health services follows AUMSI policies and processes for medical necessity review. This includes compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).

Licensed behavioral health professionals manage AUMSI behavioral health functions under the direction of the behavioral health medical director. The medical director provides supervision, oversight and evaluation of the program.

Associates do not perform triage and referral services. These services are not included in the scope of the UM Program.

Pharmacy Management
The Companies' Pharmacy Benefits Manager (PBM) delegate and AUMSI provide pharmacy UM services for the company under the direction of the VP, Health Care Management. Pharmacy reviewers perform UM services in accordance with policies created in the pharmacy and therapeutics (P&T) process.

The committees, which make up the Pharmacy and Therapeutics (P&T) process, includes two interdependent committees, the Clinical Review Committee (CRC) and the Value Assessment Committees (VACs). The purpose of the P&T process is to make clinically based recommendations that will help promote access to quality medications and, when appropriate, cost effective utilization of benefits. The committees meet quarterly and ad hoc to make determinations regarding the drug formulary. An evaluation of various new and existing products approved by the Food and Drug Administration (FDA) is conducted at the quarterly and ad hoc meetings. Appropriate professionals, including actively practicing physicians and pharmacists, participate in the evaluation. These evaluations result in policies, which identify the appropriate procedures for administering pharmacy benefits related to formulary/edit management. The procedures are reviewed annually and updated as necessary. The review process is supported by pharmacy technicians, registered nurses, pharmacists, and peer clinical reviewers.

The purpose of the CRC is to clinically review drugs for efficacy, safety, effectiveness, and clinical aspects in comparison to similar drugs within a therapeutic class or used to treat a particular condition. The CRC develops and implements the necessary policies and procedures to consistently document how the Clinical Designation was established for efficacy and safety of a drug product. The CRC shall also consider effectiveness data, when available, and Clinical Attributes.

The purpose and function of the VAC is to make recommendations regarding the formulary/tier assignment or formulary/tier edits applied to covered prescription medication (hereinafter referred to as "Tier" or Tiering") in accordance with CRC determinations. For formularies that do not have a tiered copayment structure, drugs are assigned either a formulary or a non-formulary status. There are three Value Assessment Committees including Commercial, Medicaid and Medicare business. The VAC considers the CRC's *Clinical Designation* and any *Clinical Comment*(s) before Tier placement is determined.

Prior authorization of benefits (PAB) is required for certain drugs. The goal of this program is to confirm the appropriateness of drug selection to ensure compliance with FDA-approved indications and relevant safety precautions.

Anthem, in collaboration with its PBM delegate and under the direction of the VP Clinical & Specialty Pharmacy, Clinical Pharmacy Service, has programs and processes in place to provide important patient safety information to physicians, covered persons and pharmacists when appropriate. Overseen by Anthem, the Companies' PBM delegate monitors a point of sale drug interactions system that alerts pharmacists of

potentially dangerous drug-to-drug interactions that may occur upon dispensing a medication. In addition, the Companies' PBM delegate monitors FDA-required and voluntary drug withdrawals as well as Class I and II recalls that may occur and notifies affected members and prescribers of medication withdrawals and Class I and II drug recalls when due to safety concerns.

A collaborative environment exists between the Pharmacy program and medical and behavioral health providers and programs, supporting AUMSI's ability to identify and act on improvement opportunities. Pharmacy Program provides quarterly updates to the AUMSI QIC.

A. Quality Activities for UM Program

The Program includes monitoring and evaluation of components across UM as well as compliance with regulatory and accreditation requirements. The Program includes activities and analyses conducted by key associates from Utilization Management, Quality Improvement, Grievances and Appeals, Behavioral Health, Pharmacy and Regulatory Compliance.

The UM program includes the following activities:

1. Confidentiality and Conflict of Interest
2. Orientation and training
3. Associate performance and quality assurance
4. Health and safety of covered persons
5. Satisfaction with UM process
6. UM Quality improvement activities
7. Compliance with regulatory and accreditation requirements, as applicable
8. Delegation of Utilization Management, as applicable

The data sources used for quality improvement measurements may include, but are not limited to, the following:

- UM data
- Complaint and appeal data
- Phone accessibility data
- Satisfaction survey results related to UM

1. Confidentiality and Conflict of Interest

Associates will keep covered persons' information confidential in accordance with applicable federal and state laws. These laws protect confidentiality and require divulging or collecting the minimum amount of information necessary to conduct business activities. We consider all activities and documents to be confidential. We maintain these documents in compliance with the Corporate Privacy Policies and Procedures.

All materials, discussions, deliberations, records and decisions of the AUMSI Quality Improvement Committee (QIC) are confidential. We label committee documents confidential for internal use and distribution only. AUMSI associates, committee

members, and board members must sign a statement that they understand their responsibility to preserve confidentiality, including, but not limited to, protection of both members' medical information and AUMSI's proprietary information. Contracts and/or Business Associate Agreements for committee members who are not AUMSI associates (e.g., community-based physicians and delegated organizations) include a confidentiality statement.

2. Orientation and Training

Clinical and non-clinical associates, both employed and contracted, are required to complete a formal training program prior to assuming assigned roles and responsibilities. As applicable to job function, Program curriculum includes, but is not limited to, education on:

- Organizational structure
- Products and benefit plans including transitions between benefit plans
- AUMSI and Corporate policies and procedures and operational guidelines
- Use of Medical Policies and Clinical Guidelines and Pharmacy Prior Approval Process guidelines
- Use of Medical Policy exceptions and Priority Complex Case process
- Hierarchy of decision making
- Medical management and other company systems
- Telephone and email protocols
- Clinical review and notification process
- Regulatory and accreditation requirements
- Standards and tools for medical director decision statement
- Complaint and appeal processes
- Audits and performance evaluations
- Current accreditation/certification standards (e.g., URAC, NCQA), as appropriate to job function
- State and Federal regulatory requirements
- Identification and prevention of fraud and abuse
- Conflict of interest
- Confidentiality
- Delegation oversight, as necessary

The Company provides educational opportunities throughout the year. Training includes federal and state regulatory requirements related to job functions.

Associates must meet annual training requirements for professional competency and will maintain a record of all education received.

3. Associate Performance and Quality Assurance

No less than annually, health plans will evaluate the consistency with which peer clinical reviewers and health professionals involved in the utilization management process apply criteria in decision making as explained in URA -14, Inter-rater Reliability Assessments of Clinical Professionals Policy.

4. **Health and Safety of Covered persons**
   Health plan staff must follow processes outlined in URA-16 Consumer Safety Policy when they suspect a covered person is experiencing an emergency, abuse, neglect or domestic violence. This process includes how to report safety issues to the proper authorities.

5. **Satisfaction with UM Process**
   Health plans conduct an analysis at least annually, to assess the satisfaction of covered persons, providers and clients with the UM Process. Information may come from surveys, complaints, and/or appeals. This analysis forms the basis for interventions to improve satisfaction.

6. **UM Quality Improvement Activities**
   Health plans maintain at least two ongoing quality improvement activities at all times. The Program selects activities based on key indicators of quality and relies on statistically valid data. If the project is clinical in nature, a senior clinical associate will be involved in judgments about the clinical aspects of performance. Various associates and managers will be involved in designing and implementing strategies to improve performance over a projected timeframe. Each activity includes a baseline measurement, quantifiable measures, established measurable goals, projected timeframes for meeting goals and re-measurements at least annually. Staff will document changes or improvements and conduct a barrier analysis when activities fail to meet performance goals. QIPs will focus on error reduction, member safety and/or performance improvement.

7. **Compliance with Regulatory and Accreditation Requirements (as applicable)**
   We maintain the UM licenses that are required to perform utilization review (UR). To ensure compliance with applicable laws and regulations, AUMSI maintains a regulatory compliance program. The program tracks UR laws and federal and state regulations in the states where we provide UR services. We provide support and communicate regulatory and accreditation requirements to the UM and other appropriate areas. We will establish and maintain UR policies and procedures as may be required to ensure compliance with applicable laws, regulations, covered persons' contracts, health care provider contracts, and accreditation standards and will respond promptly to detected problems and take corrective action as needed. We review policies and procedures at least annually and revise or develop new policies as necessary. Associates will have an opportunity to provide input, as practicable and appropriate, into the policy and procedure development process. The AUMSI QIC issues final approval prior to implementation of policies and procedures.

8. **Delegation of Utilization Management**
   As required by accreditation or regulatory requirements, we follow Anthem's Delegate/Vendor Oversight and Management Policies and Procedures, which sets forth the guidelines that associates must follow when performing delegation activities.

B. Utilization Management (UM) Program

The Utilization Management (UM) Program promotes objective systematic ongoing measurement, monitoring and evaluation of services and to implement quality improvement activities based upon findings.

The scope of the UM Program includes services that are provided by way of telephonic, electronic (e.g. email, Web, and facsimile) and on-site reviews. Types of reviews performed are prospective, continued stay, and retrospective review, as well as behavioral health management, pharmacy management, appeals and other specialty UM Programs for the following commercial products:

- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
- Point of Service (POS)
- Indemnity
- Health Insurance Marketplace Products,
- Commercial group and individual benefit plans
- Others, as applicable

The Program manages each request appropriately. Staff will refer to case and disease management as needed. When making determinations, staff will consider the type of delivery system and membership served.

Requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan do not require peer clinical review. These are guided by local claims processing guidelines. Other benefit determinations require evaluation by peer clinical reviewers before an adverse determination can be made. We will follow federal and state mandates for all determinations.

The Program addresses the following:

1. Clinical review criteria development and new technology evaluation
2. Qualified health professionals
3. Accessibility
4. Timeliness and notification of UM determinations
    - prospective review
    - continued stay review
    - retrospective review
    - predetermination
    - lack of information
    - re-review
    - peer-to-peer conversations
5. Discharge planning
6. On-site review
7. Emergency services
8. Complaint and appeal process

1. **Clinical Review Criteria Development and New Technology Evaluation**
Decision criteria applied to utilization review determinations in accordance with the covered person's specific benefit plan may include, but are not limited, to the following:

Criteria Set	Criteria Development Committee
Medical Policy and Clinical UM Guidelines	Medical Policy and Technology Assessment Committee (MPTAC)
MCG	Medical Policy and Technology Assessment Committee (MPTAC)
Pharmacy Criteria/Prior Authorization Guidelines	Clinical Review Committee (CRC)
Behavioral Health Clinical UM Guidelines	National Behavioral Health Clinical Advisory Committee (subcommittee of MPTAC)
AIM Specialty Health Guidelines	AIM Specialty Health
Applicable state and federal regulatory requirements	State and federal legislatures and regulators.

In some cases, pre-review screen scripts support the application of medical policies and clinical guidelines.

The Medical Policy and Technology Assessment Committee (MPTAC) develop decision criteria for most topics. The principal component of the process is the review for development of medical necessity and investigational policy position statements. MPTAC evaluates selected new medical technologies, procedures and new uses of existing technologies and/or procedures. The technologies include devices, biologics, specialty pharmaceuticals, and behavioral health services. MPTAC also reviews MCG and revises as necessary to be consistent with other policies and guidelines.

The medical policy, ADMIN.00001 Medical Policy Formation, describes the structure and processes of MPTAC. The committee is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. Voting membership includes external physicians in clinical practices and participating in networks, external physicians in academic practices and participating in networks and internal medical directors.

In addition to policies developed or approved through MPTAC, AUMSI medical reviewers use criteria developed by other criteria development committees listed in the table above.

Each criteria development committee reviews all of its criteria at least annually and revises them to develop new criteria as necessary. The criteria are available without charge to providers and covered persons who can request them by contacting their local Anthem UM Department. The AUMSI QIC annually adopts the criteria for AUMSI's use. MPTAC provides quarterly updates to the AUMSI QIC.

Medical policies are intended to reflect the current scientific data and clinical thinking. While medical policy will set forth position statements for policy development and updating regarding the medical necessity of individual technologies, etc., Federal and State law, as well as contract language, including

definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

In the absence of specific medical policy, physician reviewers conduct case-by-case individual reviews. A physician designated by the health plan, will review the request using the technology assessment criteria and appropriate standards that may include, but are not limited to, any of the following: peer-reviewed literature, other organizations' technology evaluations including the Blue Cross Blue Shield Association, Agency for Healthcare Research and Quality (AHRQ), various medical specialty societies' guidelines and assessments and the clinician's professional judgment. Refer to the following policy for details: ADMIN.00006 Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline.

2. **Qualified Health Professionals**
Health Professionals, Peer Clinical and Appeal Reviewers support the clinical review process. Under the guidance of a licensed health professional, non-clinical administrative staff may collect non-clinical data or structured clinical data and may approve cases that do not require clinical review. When performing utilization review, health professionals make determinations according to clinical review criteria. Peer clinical reviewers complete all reviews that do not meet medical necessity criteria. Board-certified internal physicians or consultants from appropriate specialty areas conduct appeal reviews. URA-01 Definitions policy further explains the qualifications and tasks.

   We do not employ a system for reimbursement, bonuses, or incentives to staff or health care providers based directly on covered person's utilization of health care services.

3. **Accessibility**
Staff are available during and after normal business hours by a toll free telephone number or facsimile to provide communication services to health care providers and covered persons as explained in policy, URA-10 Access Standards.

4. **Timeliness and Notification of UR Determinations**
We review relevant clinical information before making a determination. We inform requesting clinicians when we need additional information for a determination (see Lack of Information below). We make determinations within required timeframes and communicate them as explained in policies URA-02 UR Process and Timeframes and URA-03 Notification of UR Determinations.

   The following is a brief description of the various UM processes:

   - **Prospective Review**
   Prospective (pre-service) review is utilization review conducted on a health care service or supply prior to its delivery to the covered person. Medical necessity

includes a review of both the service and the setting. We certify cases that meet the medical necessity requirements of the health benefit plan.

- **Continued Stay Review**
  Continued stay review is utilization review conducted during a covered person's ongoing stay in a facility or course of treatment. We certify extensions of stay when requests meet continued stay medical necessity criteria and health benefit plan contract requirements.

- **Retrospective Review**
  Retrospective (post-service) review is utilization review conducted after a health care service or supply has been provided to a covered person.

- **Predetermination**
  We will provide predetermination medical necessity review at the covered person's or health care provider's request to determine benefit coverage prior to having a service rendered. (i.e., in cases where no review is mandated by the UM requirements of the particular plan).

- **Lack of Information**
  Some requests for utilization review come in without sufficient pertinent clinical information available to process the request. When this occurs, we may request additional information from the covered person or health care provider as explained in the AUMSI policy, URA-02 UR Process and Timeframes

- **Re-Review**
  The re-evaluation of an initial UM adverse determination (medical necessity or investigational) by the UM area.

- **Peer-to-Peer Conversations**
  Peer clinical reviewers are available for peer-to-peer conversations to discuss impending or issued adverse determinations as explained in policy, URA-27 Peer-to-Peer Conversations policy.

5. **Discharge Planning**
   During discharge planning, we will collaborate and communicate with applicable entities to ensure continuity of care occurs between the acute care facility and other levels of care. In this process, we assess the covered person's plan of care and work with the facilities to arrange and coordinate health services for the covered person. Contract limitations are reviewed, when necessary, to assist with discharge arrangements.

6. **On-Site Review**
   Licensed nurses may perform on-site utilization reviews at specific hospitals or other facilities as explained in policy, URA-11 On-Site Facility Reviews.

7. **Emergency Services**
   We will render a favorable determination for coverage of emergency medical care services as explained in policy, URA-23 Emergency Medical Care.

8. **Complaint and Appeal Process**
   We maintain processes to review verbal and written utilization management complaints as explained in the URA-13 Complaints UR Process policy.
   We also maintain processes to provide covered persons, health care providers and authorized representatives the right to request a reversal of an adverse determination. URA-04 Appeals of Adverse Determinations, URA-06 Notification of Appeal Decisions and URA-07 External Appeal policies explain these processes.

9. **Information Systems**
   The Company's information technology team maintains an electronic system for collecting, storing and analyzing UM information. The system provides for data integrity, confidentiality and security.

VI. PROGRAM AUTHORITY, ACCOUNTABILITY and COMMITTEE STRUCTURE

AUMSI Board of Directors
AUMSI's Board of Directors, have designated the AUMSI Quality Improvement Committee (QIC) as responsible for development of the UM Program. On an annual basis the Board reviews and approves the UM Program.

AUMSI Quality Improvement Committee (QIC)
The AUMSI QIC is comprised of predominantly QI and UM leadership from the Companies listed in Appendix B.

Authority and accountability for quality improvement activities and processes is the responsibility of the AUMSI QIC. The CMO of AUMSI chairs the committee. The committee meets at least quarterly and serves as a point of interdepartmental integration for quality improvement activities and operations as they relate to AUMSI's UM activities. The committee provides ongoing reporting to the AUMSI Board of Directors and periodically provides reports to Commercial/Exchange Quality Improvement Committee (CEQIC).

The committee is comprised of members from the following areas:

- Accreditation
- Regulatory Compliance
- Legal Counsel
- QI, UM and G&A leadership
- Clinical Compliance
- Designated Medical Directors, Anthem Care Management
- UniCare Medical Director
- Behavioral Health Medical Director

- Clinical Pharmacist
- Enterprise Vendor Management

The committee's role includes the following:

- Annually adopts review criteria for AUMSI's use
- Annually reviews and approves AUMSI policies and procedures and state addenda and as revisions occur
- Annually reviews and approves the AUMSI UM Program Description, QI Work Plan and QI Annual Report and as revisions occur
- Annually evaluates the effectiveness of the Program and monitors progress in meeting Performance Measures
- Reviews and monitors UM, appeal, access and complaint timeliness results
- Provides guidance on UM-related quality improvement activities to initiate
- Approves and monitors UM-related quality improvement activities
- Identifies and provides oversight of appropriate corrective action plans
- Reviews and accepts reports from the relevant committees
- At least annually, considers additions or deletions to the committee roster in order to best represent the UM structure within the Companies
- Monitors reports of delegates' performance, as applicable, and
- Maintains approved records of all committee meetings

Commercial/ Exchange Quality Improvement Committee (CEQIC)

The Commercial/Exchange Quality Improvement Committee (CEQIC) has been formally designated by the Board of Directors for the Companies the responsibility of overseeing the quality activities of the QI Program. The CEQIC provides ongoing guidance, oversight, and monitoring as appropriate, and evaluates the effectiveness of the QI Program as a whole. The CEQIC has designated the day-to-day management of quality including QI Projects and activities to the business areas that support quality. The CEQIC includes representation of Medical Directors and clinical associates from:

- Behavioral Health Commercial QIC, Cancer Care QIC, Care Management QIC, Regional Quality Committees; and
- Clinical Pharmacy, Clinical Quality, Legal, Medical Policy, Pharmacy Operations, National Provider Solutions, and Service Quality.

As designated by the Quality leadership, the Medical Director who chairs the CEQIC is responsible to help ensure that cross-disciplinary collaboration occurs to improve the quality of member care and services. The CEQIC Chair engages with the leadership of the various CEQIC Subcommittees and other areas of the organization to help ensure quality goals and accreditation standards are being met; and members are receiving the benefit of programs that are interconnected, non-duplicative, and value-added in nature.

The CEQIC and other committees are charged with the responsibility for monitoring and evaluating the results of quality initiatives, and initiating performance improvement activities identified, and recommend follow-up as needed.

Subcommittees, teams, and work groups are formed to address the needs of the population. These groups can be clinical and/or service-focused, and are usually cross-departmental; and use continuous quality techniques to plan, measure, and evaluate interventions, with the goal of improving clinical outcomes, cost of care, and service to members.

VII. PROGRAM LEADERSHIP

President and CEO, AUMSI
The Board of Directors designates the oversight of UM program activities to the President and CEO of AUMSI. The President delegates the day-to-day oversight of and responsibility for the development, implementation and evaluation of the UM Program to the CMO of AUMSI.

Chief Medical Officer, AUMSI
The CMO of AUMSI is actively involved in implementing and providing guidance to the clinical aspects of AUMSI's UM Program. Qualifications include:

- Board certification;
- Current, unrestricted clinical license (the license may have a restriction that is unrelated to job functions unless state requirements prohibit such a restriction;
- Post-graduate experience in direct patient care; and
- Periodic consultation with practitioners in the field (either directly or through designees (e.g., local, regional, or brands); and

The CMO is designated by the President and CEO of AUMSI to oversee the UM Program activities. The CMO has overall responsibility for the success of the UM Program and is ultimately accountable to ensure that corrective actions and follow-up occur in pursuit of improvement in medical, behavioral health care, and pharmacy utilization management services. The CMO is responsible for reporting results of UM Program activities to the President and CEO of AUMSI.

Medical Directors
Qualified medical directors provide supervision and guidance to medical directors, consultant physicians, and associates performing UM services. Designated medical directors are members of the AUMSI Quality Improvement Committee and provide input into policies and process. These medical directors ensure that qualified clinicians are accountable to AUMSI for determinations affecting covered persons.

Medical Director, Behavioral Health
The behavioral health medical director is actively involved in implementing and providing supervision and guidance for the behavioral health aspects of the UM Program and to the behavioral health associates who perform UM services.

Other Departments
Management and associates within AUMSI and the Companies are involved in the design and implementation of quality improvement activities for the UM program. These areas include:

- Quality improvement
- Medical and behavioral health
- Pharmacy
- Enterprise Clinical Compliance
- Enterprise Vendor Management
- Medical policy
- Legal
- Grievances and appeals
- Credentialing
- Information systems
- Others, as necessary

AUMSI's standing workgroup meetings provide a forum for inter-departmental development, communication, and coordination of the UM quality improvement activities.

VIII. COMPANY PROGRAMS SUPPORTING UM PROGRAM

AUMSI is a wholly owned subsidiary of Anthem, and is represented in the Anthem QI Program integration activities. A collaborative environment exists between AUMSI and the Companies as a whole.

Anthem pursues opportunities to integrate and/or develop appropriate corporate-level programs to support collaboration. These programs include the Companies' committees, councils and other bodies. The Anthem QI program responsibilities include national activities and oversight.

IX. PROGRAM DOCUMENTS, EVALUATION and PLANNING

UM Program Description

The UM Program Description is a written description of the UM structure that defines the scope, goals, objectives and planned activities within AUMSI. On an annual basis, AUMSI evaluates the UM Program Description to ensure that the structure, scope, goals, objectives and planned activities are current and consistent with corporate and business strategic plans.

The AUMSI QIC provides initial approval of the Program, followed by the AUMSI Board of Directors for final approval.

Quality Improvement Work Plan

The AUMSI QI Work Plan serves as an ongoing monitoring and evaluation tool for AUMSI's UM activities. The Plan outlines identified performance measures, realistic goals, baseline measures where appropriate and time-frames that are re-measured at least annually.

On an annual basis, AUMSI evaluates the QI Work plan to determine if current performance measures will continue or to establish and prioritize new measures.

The AUMSI QIC provides the approval of the Quality Improvement Work Plan.

Quality Improvement Annual Report
The AUMSI Quality Improvement Annual Report analyzes key performance measures each year to evaluate current activities and identify new opportunities for improvement. The QI annual report documents evaluation of the UM Program goals, effectiveness and scope.

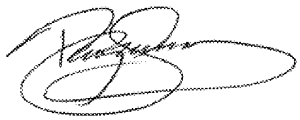
The AUMSI QIC provides the approval of the Quality Improvement Annual Report.

Anthem UM Services, Inc.
Summary of Revisions to the 2017 UM Program Description

Topic	Change(s)
I. Mission Statement	No change
II. Purpose	No change
III. Goals	No change
IV. Objectives	No change
V. Scope of Utilization Management Program and Program Operations	Pharmacy Management • Revised the titles of who provides direction for pharmacy UM services. • Removed the paragraph that defines purpose of P&T as some of the information was duplicate. The other information was added to the first paragraph that discusses P&T process.
A. Quality Activities for UM Program	Revised the name of the Enterprise Delegation Policy.
B. Utilization Management Program	Removed the Voluntary Authorization from Predetermination to be consistent throughout the Program. Changed Reconsideration to Re-Review and revised the definition to be consistent with enterprise process.
VI. Program Authority, Accountability and Committee Structure	Added reviews and monitors access measures under the role of the AUMSI QIC. Revised the entire section of the Enterprise Commercial/Marketplace Quality Committee to be consistent with QI Program and changed the title of the committee.
VII. Program Leadership	No change
VIII. Company Programs Supporting UM Program	No change
IX. Program Documents, Evaluation and Planning	No change
Appendix A Utilization Management Program Committee Structure	Revised title of Commercial/Exchange Quality Improvement Committee.
Appendix B Companies Served by Anthem UM Services, Inc.	No change

Review and Approval of the Utilization Management Program Description by:

AUMSI Quality Improvement Committee — November 15, 2016



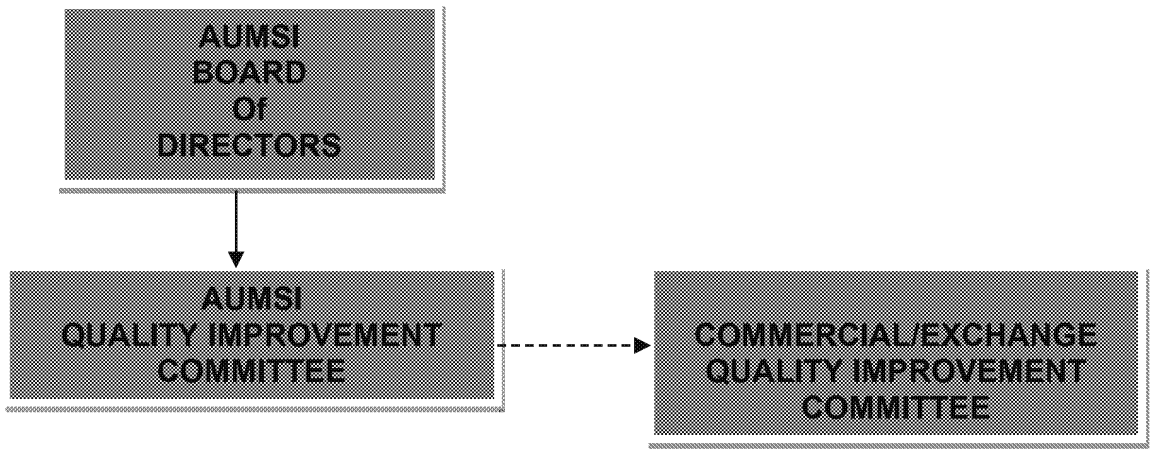
November 15, 2016

Terrence Flannery, M.D. — **Date**

Chief Medical Officer, Anthem UM Services, Inc.

Chairman AUMSI QIC

APPENDIX A
AUMSI Committee Structure



APPENDIX B

Companies Served by Anthem UM Services, Inc.

[CONFIDENTIAL CLIENT LIST – NOT INCLUDED IN THIS VERSION]

EXHIBIT 10

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Anthem, Inc. designates Anthem UM Services, Inc. (AUMSI), a wholly owned subsidiary, to perform utilization management on behalf of the Companies listed on Appendix B. This document refers to these companies collectively as "Company." Throughout this document, unless otherwise specified, "we" refers to AUMSI.

I. MISSION STATEMENT

Anthem UM Services, Inc. (AUMSI) provides a consistent operational, accreditation, regulatory, and quality improvement framework for the provision of utilization management services across the Companies.

II. PURPOSE

This program description outlines how AUMSI oversees quality improvement activities related to utilization management, enables regulatory and accreditation compliance, and promotes operational consistency while maintaining the flexibility to respond to customer needs. These contributions will help to achieve the purpose statement of Anthem, Inc.

Together, we are transforming health care with trusted and caring solutions

III. GOALS

A. Promote the delivery of medically necessary healthcare services in a cost-effective manner.
B. Perform utilization management services for covered persons in eligible HMO, POS, PPO, EPO, indemnity, Health Insurance marketplace products, commercial group and individual benefit plans and others, as applicable.
C. Promote local coordination of services in collaboration with local business units.
D. Establish, implement, assess and assure that utilization management processes meet the needs and expectations of clients and covered persons.
E. Promote quality of service and effective utilization of service to all clients and covered persons.
F. Monitor and improve, where indicated, access to services when relevant to AUMSI's utilization management (UM) activities.
G. Monitor, analyze and report program performance.

H. Develop and maintain a well-integrated, culturally sensitive system to identify, measure, and improve quality outcomes through standardized and collaborative activities.
I. Maintain compliance with accreditation standards and local, state and federal regulatory requirements.
J. Evaluate the effectiveness of the UM Program and the resources dedicated to it specific to UM.

IV. OBJECTIVES

A. Provide covered persons, health care providers and authorized representatives sufficient access to utilization management programs
B. Establish and maintain processes to obtain and communicate relevant clinical information in order to make the appropriate determination.
C. Establish a consistent process for providing utilization determinations in a timely manner to accommodate the clinical urgency of each situation.
D. Provide health care providers and covered persons with sufficient information to understand both the reasons for an adverse determination and how to initiate an appeal.
E. Promote consistency in the use of clinical guidelines to make utilization and level of care coverage determinations.
F. Establish education and training for all levels of staff.
G. Establish standards of service and access reflecting current national and competitive benchmarks.
H. Establish monitoring programs to investigate trends and/or patterns of UM services.
I. Design and implement activities to improve program performance.
J. Evaluate the impact of trends on satisfaction.
K. Communicate the results of quality improvement related activities to staff, and the AUMSI QIC or other committees, as appropriate.

V. SCOPE OF UM PROGRAM AND PROGRAM OPERATIONS

Utilization Management is a process used to assess the medical necessity, efficiency, and/or appropriateness of health care services in a fair, impartial and consistent manner. UM evaluates the setting of care, and treatment plans in accordance with the definitions contained in the health benefit plan documents. AUMSI encompasses medical, behavioral health and pharmacy services.

Medical necessity review requires that denial decisions be made only by an appropriate clinical professional. Denials resulting from medical necessity review are within scope of review.

Decisions about the following require medical necessity review:

1. Covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits.

2. Preexisting conditions, when the member has creditable coverage and the organization has a policy to deny preexisting care or services.
3. Care or services whose coverage depends on specific circumstances.
4. Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits.
5. Out-of-network services that are only covered in clinically appropriate situations.
6. Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
7. "Experimental" or "investigational" requests, unless the requested services or procedures are specifically excluded from the benefits plan and deemed never medically necessary under any circumstance in the organization's policies, medical necessity review is not required.

Decisions about the following do not require medical necessity review:

1. Services in the member's benefits plan that are limited by number, duration or frequency.
2. Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
3. Care that does not depend on any circumstances.

Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met in-network (e.g., a service or procedure not provided in-network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards).

If the certificate of coverage or summary of benefits specifies that the organization never covers an out-of-network service for any reason or if the request does not indicate the member has a specific clinical need for which out-of-network coverage may be warranted, the request does not require medical necessity review.

Appropriate practitioners review all medical necessity denials for requested health care services offered under the Company's medical benefits. No practitioner review is required for requests of medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits.

Behavioral Health Management

Utilization management for behavioral health services follows AUMSI policies and processes for medical necessity review. This includes compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).

Licensed behavioral health professionals manage AUMSI behavioral health functions under the direction of the behavioral health medical director. The medical director provides supervision, oversight and evaluation of the program.

Associates do not perform triage and referral services. These services are not included in the scope of the UM Program.

Pharmacy Management

The Companies' Pharmacy Benefits Manager (PBM) delegate and AUMSI provide pharmacy UM services for the company under the direction of the Vice President, Health Care Management. Pharmacy reviewers perform UM services in accordance with policies created in the Pharmacy and Therapeutics (P&T) process.

The Pharmacy and Therapeutics (P&T) process includes two interdependent committees, the Clinical Review Committee (CRC) and the Value Assessment Committee (VAC). The purpose of the P&T process is to make clinically based recommendations that will help promote access to quality medications and, when appropriate, cost effective utilization of benefits. The committees meet quarterly and ad hoc to make determinations regarding the drug formulary. An evaluation of various new and existing products approved by the Food and Drug Administration (FDA) is conducted at the quarterly and ad hoc meetings. Appropriate professionals, including actively practicing physicians and pharmacists, participate in the evaluation. These evaluations result in policies, which identify the appropriate procedures for administering pharmacy benefits related to formulary/edit management. The procedures are reviewed annually and updated as necessary. The review process is supported by pharmacy technicians, registered nurses, pharmacists, and peer clinical reviewers.

The purpose of the CRC is to clinically review drugs for efficacy, safety, effectiveness, and clinical aspects in comparison to similar drugs within a therapeutic class or used to treat a particular condition. The CRC develops and implements the necessary policies and procedures to consistently document how the Clinical Designation was established for efficacy and safety of a drug product. The CRC shall also consider effectiveness data, when available, and Clinical Attributes.

The purpose and function of the VAC is to make recommendations regarding the formulary/tier assignment or formulary/tier edits applied to covered prescription medication (hereinafter referred to as "Tier" or Tiering") in accordance with CRC determinations. For formularies that do not have a tiered copayment structure, drugs are assigned either a formulary or a non-formulary status. There is one Value Assessment Committee for all lines of business that includes Commercial, Medicaid and Medicare business. The VAC considers the CRC's *Clinical Designation* and any *Clinical Comment*(s) before Tier placement is determined.

Prior authorization of benefits (PAB) is required for certain drugs. The goal of this program is to confirm the appropriateness of drug selection to ensure compliance with FDA-approved indications and relevant safety precautions.

Anthem, in collaboration with its PBM delegate and under the direction of the Vice President, Clinical & Specialty Pharmacy, Clinical Pharmacy Service, has programs and

processes in place to provide important patient safety information to physicians, covered persons and pharmacists when appropriate. Overseen by Anthem, the Companies' PBM delegate monitors a point of sale drug interactions system that alerts pharmacists of potentially dangerous drug-to-drug interactions that may occur upon dispensing a medication. In addition, the Companies' PBM delegate monitors FDA-required and voluntary drug withdrawals as well as Class I and II recalls that may occur and notifies affected members and prescribers of medication withdrawals and Class I and II drug recalls when due to safety concerns.

A collaborative environment exists between the Pharmacy program and medical and behavioral health providers and programs, supporting AUMSI's ability to identify and act on improvement opportunities. The Pharmacy Program provides quarterly updates to the AUMSI QIC.

A. Quality Activities for UM Program

The Program includes monitoring and evaluation of components across UM as well as compliance with regulatory and accreditation requirements. The Program includes activities and analyses conducted by key associates from Utilization Management, Quality Improvement, Grievances and Appeals, Behavioral Health, Pharmacy and Regulatory Compliance.

The UM program includes the following activities:

1. Confidentiality and Conflict of Interest
2. Orientation and training
3. Associate performance and quality assurance
4. Health and safety of covered persons
5. Satisfaction with UM process
6. UM Quality improvement activities
7. Compliance with regulatory and accreditation requirements, as applicable
8. Delegation of Utilization Management, as applicable

The data sources used for quality improvement measurements may include, but are not limited to, the following:

- UM data
- Complaint and appeal data
- Phone accessibility data
- Satisfaction survey results related to UM

1. Confidentiality and Conflict of Interest

Associates will keep covered persons' information confidential in accordance with applicable federal and state laws. These laws protect confidentiality and require divulging or collecting the minimum amount of information necessary to conduct business activities. We consider all activities and documents to be confidential. We maintain these documents in compliance with the Corporate Privacy Policies and Procedures.

All materials, discussions, deliberations, records and decisions of the AUMSI Quality Improvement Committee (QIC) are confidential. We label committee documents confidential for internal use and distribution only. AUMSI associates, committee members, and board members must sign a statement that they understand their responsibility to preserve confidentiality, including, but not limited to, protection of both members' medical information and AUMSI's proprietary information. Contracts and/or Business Associate Agreements for committee members who are not AUMSI associates (e.g., community-based physicians and delegated organizations) include a confidentiality statement.

2. Orientation and Training

Clinical and non-clinical associates, both employed and contracted, are required to complete a formal training program prior to assuming assigned roles and responsibilities. As applicable to job function, Program curriculum includes, but is not limited to, education on:

- Organizational structure
- Products and benefit plans including transitions between benefit plans
- AUMSI and Corporate policies and procedures and operational guidelines
- Use of Medical Policies and Clinical Guidelines and Pharmacy Prior Approval Process guidelines
- Use of Medical Policy exceptions and Priority Complex Case process
- Hierarchy of decision making
- Medical management and other company systems
- Telephone and email protocols
- Clinical review and notification process
- Standards and tools for medical director decision statement
- Complaint and appeal processes
- Audits and performance evaluations
- Current accreditation/certification standards (e.g., URAC, NCQA), as appropriate to job function
- State and Federal regulatory requirements
- Identification and prevention of fraud and abuse
- Conflict of interest
- Confidentiality
- Delegation oversight, as necessary

The Company provides educational opportunities throughout the year. Training includes federal and state regulatory requirements related to job functions.

Associates must meet annual training requirements for professional competency and will maintain a record of all education received.

3. **Associate Performance and Quality Assurance**
   An annual formal appraisal including review of relevant documentation produced by each staff member is completed as documented in policy URA-20 Annual Staff Assessment.

   No less than annually, health plans will evaluate the consistency with which peer clinical reviewers and health professionals involved in the utilization management process apply criteria in decision making as explained in policy URA 14, Inter-rater Reliability Assessments of Clinical Professionals.

4. **Health and Safety of Covered persons**
   Health plan staff must follow processes outlined in policy URA-16 Consumer Safety when they suspect a covered person is experiencing an emergency, abuse, neglect or domestic violence. This process includes how to report safety issues to the proper authorities.

5. **Satisfaction with UM Process**
   Health plans conduct an annual assessment of satisfaction with the UM Process which will include consumer and client satisfaction. For plans subject to NCQA, this assessment will also include provider satisfaction.

   Information may come from surveys, complaints, and/or appeals and produces valid and reliable results. To identify areas of improvement, quantitative and qualitative analyses are completed. This analysis forms the basis for interventions to improve satisfaction.

6. **UM Quality Improvement Activities**
   Health plans maintain at least two ongoing quality improvement activities at all times. The Program selects activities based on key indicators of quality and relies on statistically valid data. If the project is clinical in nature, a senior clinical associate is involved in judgments about the clinical aspects of performance. Various associates and managers will be involved in designing and implementing strategies to improve performance over a projected timeframe.

   Each activity includes a baseline measurement, quantifiable measures, established measurable goals, projected timeframes for meeting goals and re-measurements at least annually. Staff will document changes or improvements and conduct a barrier analysis when activities fail to meet performance goals. QIPs will focus on error reduction, or performance improvement.

7. **Compliance with Regulatory and Accreditation Requirements (as applicable)**
   We maintain the state UM licenses that are required to perform utilization review (UR). To enable compliance with applicable laws and regulations, AUMSI maintains a regulatory compliance program.

The program tracks federal and state UR laws and regulations in the states where we provide UR services. We establish and maintain UR policies and procedures as may be required to enable compliance with applicable laws, regulations, covered persons' contracts, health care provider contracts, and accreditation standards and respond promptly to detected problems and take corrective action as needed. We review policies and procedures at least annually and revise or develop new policies as necessary. Associates will have an opportunity to provide input, as practicable and appropriate, into the policy and procedure development process. The AUMSI QIC issues final approval prior to implementation of policies and procedures.

We provide support and communicate regulatory and accreditation requirements to UM and other appropriate areas.

8. **Delegation of Utilization Management**
   We follow Anthem's Delegate/Vendor Oversight and Management Policies and Procedures and Performance Management Oversight for Entities that Support Pharmacy Clinical Initiatives. Both policies set forth the guidelines that associates must follow when performing delegation activities.

B. Utilization Management (UM) Program

The Utilization Management (UM) Program promotes objective systematic ongoing measurement, monitoring and evaluation of services and implementation of quality improvement activities based upon findings.

The scope of the UM Program includes services that are provided by way of telephonic, electronic (e.g. email, Web, and facsimile) and on-site reviews. AUMSI makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner. Types of reviews performed are prospective, continued stay, and retrospective review, as well as behavioral health management, pharmacy management, appeals and other specialty UM Programs for the following commercial products:

- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
- Point of Service (POS)
- Indemnity
- Health Insurance Marketplace Products,
- Commercial group and individual benefit plans
- Others, as applicable

The Program manages each request appropriately and takes the covered persons' circumstances into consideration. Staff will refer to case and disease management as needed. When making determinations, staff will consider the type of delivery system and membership served.

The Program addresses the following:

1. Clinical review criteria development and new technology evaluation
2. Qualified health professionals

3. Accessibility
4. Timeliness and notification of UM determinations
   - prospective review
   - continued stay review
   - retrospective review
   - predetermination
   - lack of information
   - re-review
   - peer-to-peer conversations
5. Discharge planning
6. On-site review
7. Emergency services
8. Complaint and appeal process

1. Clinical Review Criteria Development and New Technology Evaluation

Decision criteria applied to utilization review determinations in accordance with the covered person's specific benefit plan may include, but are not limited, to the following:

Criteria Set	Criteria Development Committee
Medical Policy and Clinical UM Guidelines	Medical Policy and Technology Assessment Committee (MPTAC)
MCG	Medical Policy and Technology Assessment Committee (MPTAC)
Pharmacy Criteria/Prior Authorization Guidelines	Clinical Review Committee (CRC)
Behavioral Health Clinical UM Guidelines	National Behavioral Health Clinical Advisory Committee (subcommittee of MPTAC)
AIM Specialty Health Guidelines	AIM Specialty Health
Applicable state and federal regulatory requirements	State and federal legislatures and regulators.

In some cases, pre-review screen scripts support the application of medical policies and clinical guidelines.

The Medical Policy and Technology Assessment Committee (MPTAC) develop decision criteria for most topics. The principal component of the process is the review for development of medical necessity and investigational policy position statements. MPTAC evaluates selected new medical technologies, procedures and new uses of existing technologies and/or procedures. The technologies include devices, biologics, specialty pharmaceuticals, and behavioral health services. MPTAC also reviews MCG and revises as necessary to be consistent with other policies and guidelines.

The medical policy, ADMIN.00001 Medical Policy Formation, describes the structure and processes of MPTAC. The committee is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. Voting membership includes external physicians in clinical

practices and participating in networks, external physicians in academic practices and participating in networks and internal medical directors.

In addition to policies developed or approved through MPTAC, AUMSI medical reviewers use criteria developed by other criteria development committees listed in the table above.

Each criteria development committee reviews all of its criteria at least annually and revises them to develop new criteria as necessary. The criteria are available without charge to providers and covered persons who can request them by contacting their local Anthem UM Department. The AUMSI QIC annually adopts the criteria for AUMSI's use. MPTAC provides quarterly updates to the AUMSI QIC.

Medical policies are intended to reflect the current scientific data and clinical thinking. While medical policy will set forth position statements for policy development and updating regarding the medical necessity of individual technologies, etc., Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

In the absence of specific medical policy, physician reviewers conduct case-by-case individual reviews. A physician designated by the health plan will review the request using the technology assessment criteria and appropriate standards that may include, but are not limited to, any of the following: peer-reviewed literature, other organizations' technology evaluations including the Blue Cross Blue Shield Association, Agency for Healthcare Research and Quality (AHRQ), various medical specialty societies' guidelines and assessments and the clinician's professional judgement. Refer to the following policy for details: ADMIN.00006 Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guidelines.

2. Qualified Health Professionals

Health Professionals, Peer Clinical and Appeal Reviewers support the clinical review process. Under the guidance of a licensed health professional, non-clinical administrative staff may collect non-clinical data or structured clinical data and may approve cases that do not require clinical review. When performing utilization review, health professionals make determinations according to clinical review criteria. Peer clinical reviewers complete all reviews that do not meet medical necessity criteria. Board-certified internal physicians or consultants from appropriate specialty areas conduct appeal reviews. URA-01 Definitions policy further explains the qualifications and tasks.

We do not employ a system for reimbursement, bonuses, or incentives to staff or health care providers based directly on covered person's utilization of health care services.

3. **Accessibility**
   Staff are available during and after normal business hours by a toll free telephone number or facsimile to provide communication services to health care providers and covered persons as explained in policy, URA-10 Access Standards.

4. **Timeliness and Notification of UR Determinations**
   We review relevant clinical information as outlined in URA-02 Utilization Review Process policy, before making a determination. We inform requesting clinicians when we need additional information for a determination (see Lack of Information below). We make determinations within required timeframes and communicate them as explained in policy URA-02 Utilization Review Process.

   The following is a brief description of the various UM processes:

   - **Prospective Review**
     Prospective (pre-service) review is utilization review conducted on a health care service or supply prior to its delivery to the covered person. Medical necessity includes a review of both the service and the setting. We certify cases that meet the medical necessity requirements of the health benefit plan.

   - **Continued Stay Review**
     Continued stay review is utilization review conducted during a covered person's ongoing stay in a facility or course of treatment. We certify extensions of stay when requests meet continued stay medical necessity criteria and health benefit plan contract requirements.

   - **Retrospective Review**
     Retrospective (post-service) review is utilization review conducted after a health care service or supply has been provided to a covered person.

   - **Predetermination**
     We will provide predetermination medical necessity review at the covered person's or health care provider's request to determine benefit coverage prior to having a service rendered. (i.e., in cases where no review is mandated by the UM requirements of the particular plan).

   - **Lack of Information**
     Some requests for utilization review come in without sufficient pertinent clinical information available to process the request. When this occurs, we may request additional information from the covered person or health care provider as explained in the AUMSI policy, URA-02 Utilization Review Process.

   - **Re-Review**
     The re-evaluation of an initial UM adverse determination (medical necessity or investigational) by the UM area.

- **Peer-to-Peer Conversations**
  Peer clinical reviewers are available for peer-to-peer conversations to discuss impending or issued adverse determinations as explained in policy URA-02 Utilization Review Process.

5. **Discharge Planning**
   During discharge planning, we will collaborate and communicate with applicable entities to ensure continuity of care occurs between the acute care facility and other levels of care. In this process, we assess the covered person's plan of care and work with the facilities to arrange and coordinate health services for the covered person. Contract limitations are reviewed, when necessary, to assist with discharge arrangements.

6. **On-Site Review**
   Licensed nurses may perform on-site utilization reviews at specific hospitals or other facilities as explained in policy URA-11 On-Site Facility Reviews.

7. **Emergency Services**
   We will render a favorable determination for coverage of emergency medical care services as explained in policy URA-02 Utilization Review Process.

8. **Complaint and Appeal Process**
   We maintain processes to review verbal and written utilization management complaints as explained in policy URA-13 Complaints UR Process.
   We also maintain processes to provide covered persons, health care providers and authorized representatives the right to request a reversal of an adverse determination. Policies URA-04 Appeals Process, and URA-07 External Appeal explain these processes.

9. **Information Systems**
   The Company's information technology team maintains an electronic system for collecting, storing and analyzing UM information. The system provides for data integrity, confidentiality and security.

VI. PROGRAM AUTHORITY, ACCOUNTABILITY and COMMITTEE STRUCTURE

AUMSI Board of Directors
AUMSI's Board of Directors has designated the AUMSI Quality Improvement Committee (QIC) as responsible for development of the UM Program. The Board reviews and approves the UM Program on an annual basis.

AUMSI Quality Improvement Committee (QIC)
The AUMSI QIC is comprised of predominantly QI and UM leadership from the Companies listed in Appendix B.

Authority and accountability for quality improvement activities and processes is the responsibility of the AUMSI QIC. The Chief Medical Officer (CMO) of AUMSI chairs the committee. The committee meets at least quarterly and serves as a point of interdepartmental integration for quality improvement activities and operations as they relate to AUMSI's UM activities. The committee provides ongoing reporting to the AUMSI Board of Directors and periodically provides reports to the Commercial/Exchange Quality Improvement Committee (CEQIC).

The committee is comprised of members from the following areas:

- Accreditation
- Regulatory Compliance
- Legal Counsel
- QI, UM and G&A leadership
- Clinical Compliance
- Designated Medical Directors, Anthem Care Management
- UniCare Medical Director
- Behavioral Health Medical Director
- Clinical Pharmacist
- Enterprise Vendor Management

The committee's role includes the following:

- Annually adopts review criteria for AUMSI's use
- Annually reviews and approves AUMSI policies and procedures and state specific addenda and approves revisions as they occur
- Annually reviews and approves the AUMSI UM Program Description, UM Work Plan and UM Annual Evaluation and as revisions occur
- Annually evaluates the effectiveness of the UM Program and monitors progress in meeting performance measures
- Reviews and monitors UM, appeal, access and complaint timeliness results
- Provides guidance on initiation of UM-related quality improvement activities
- Approves and monitors UM-related quality improvement activities
- Identifies and provides oversight of appropriate corrective action plans
- Reviews and accepts reports from the relevant committees
- At least annually, considers additions or deletions to the committee roster in order to best represent the UM structure within the Companies
- Monitors reports of delegates' performance, as applicable, and
- Maintains approved records of all committee meetings

VII. PROGRAM LEADERSHIP

President and Chief Executive Officer, AUMSI
The Board of Directors designates the oversight of UM program activities to the President and Chief Executive Officer (CEO) of AUMSI. The President delegates the day-to-day oversight of and responsibility for the development, implementation and evaluation of the UM Program to the CMO of AUMSI.

Chief Medical Officer, AUMSI
The CMO of AUMSI is actively involved in implementing and providing guidance to the clinical aspects of AUMSI's UM Program. Qualifications include:

- Board certification;
- Current, unrestricted clinical license (the license may have a restriction that is unrelated to job functions unless state requirements prohibit such a restriction;
- Post-graduate experience in direct patient care; and
- Periodic consultation with practitioners in the field (either directly or through designees (e.g., local, regional, or brands); and

The CMO is designated by the President and CEO of AUMSI to oversee the UM Program activities including implementation, oversight and evaluation. The CMO has overall responsibility for the success of the UM Program and is ultimately accountable to ensure that corrective actions and follow-up occurs in pursuit of improvement in medical, behavioral health care, and pharmacy utilization management services. The CMO is responsible for reporting results of UM Program activities to the President and CEO of AUMSI.

Medical Directors
Qualified medical directors provide supervision and guidance to medical directors, consultant physicians, and associates performing UM services. Designated medical directors are members of the AUMSI Quality Improvement Committee and provide input into policies and process. These medical directors ensure that qualified clinicians are accountable to AUMSI for determinations affecting covered persons.

Medical Director, Behavioral Health
The behavioral health medical director is actively involved in implementing, evaluating and providing supervision and guidance for the behavioral health aspects of the UM Program and to the behavioral health associates who perform UM services.
Qualification include:

- Must be a physician or have a clinical PhD or PsyD,
- May be a medical director, clinical director, participating practitioner from the organization or behavioral healthcare delegate (if applicable).

Other Departments
Management and associates within AUMSI and the Companies are involved in the design and implementation of quality improvement activities for the UM program. These areas include:

- Quality improvement
- Medical and behavioral health
- Pharmacy
- Enterprise Clinical Compliance
- Enterprise Vendor Management
- Medical policy
- Legal
- Grievances and appeals
- Credentialing
- Information systems
- Others, as necessary

AUMSI's standing workgroup meetings provide a forum for inter-departmental development, communication, and coordination of the UM quality improvement activities.

VIII. COMPANY PROGRAMS SUPPORTING UM PROGRAM

AUMSI is a wholly owned subsidiary of Anthem, and is represented in the Anthem QI Program integration activities. A collaborative environment exists between AUMSI and the Companies as a whole.

Anthem pursues opportunities to integrate and/or develop appropriate corporate-level programs to support collaboration. These programs include the Companies' committees, councils and other bodies. The Anthem QI program responsibilities include national activities and oversight.

IX. PROGRAM DOCUMENTS, EVALUATION and PLANNING

UM Program Description

The UM Program Description is a written description of the UM structure that defines the scope, goals, objectives and planned activities within AUMSI. On an annual basis, AUMSI evaluates the UM Program Description to ensure that the structure, scope, goals, objectives, information sources used to determine benefit coverage and medical necessity, processes and planned activities are current, appropriate and consistent with corporate and business strategic plans. AUMSI will also consider members' and client satisfaction, and for plans subject to NCQA will include provider satisfaction. (or use experienced data when evaluating the program).

The AUMSI QIC provides initial approval of the Program, followed by the AUMSI Board of Directors for final approval.

Utilization Management Work Plan

The AUMSI UM Work Plan serves as an ongoing monitoring and evaluation tool for AUMSI's UM activities. The Plan outlines identified performance measures, realistic

goals, and baseline measures where appropriate and time-frames that are re-measured at least annually.

On an annual basis, AUMSI evaluates the UM Work plan to determine if current performance measures will continue or to establish and prioritize new measures.

The AUMSI QIC provides the approval of the UM Work Plan.

Utilization Management Program Annual Evaluation
The AUMSI Utilization Program Annual Evaluation analyzes key performance measures each year to evaluate current activities and identify new opportunities for improvement. The UM annual evaluation documents assessment of the UM Program goals, effectiveness and scope.

The AUMSI QIC provides the approval of the Annual UM Program Evaluation.

Anthem UM Services, Inc.
Summary of Revisions to the 2018 UM Program Description

Topic	Change(s)
I. Mission Statement	No changes
II. Purpose	Revised the phrase "supports regulatory and accreditation compliance " to "enables regulatory and accreditation compliance"
III. Goals	No changes
IV. Objectives	No changes
V. Scope of Utilization Management Program and Program Operations	Pharmacy Management: Revised language regarding three VAC's for each line of business to: There is one Value Assessment Committee for all lines of business that includes Commercial, Medicaid and Medicare business.
	Compliance: Revised the sentence "support compliance with applicable laws and regulations, AUMSI maintains a regulatory compliance program." To enable compliance with applicable laws and regulations, AUMSI maintains a regulatory compliance program."
	Satisfaction with the UM Process: Changed from: Health plans conduct an analysis at least annually, to assess the satisfaction of covered persons, providers and clients with the UM Process. Information may come from surveys, complaints, and/or appeals. This analysis forms the basis for interventions to improve satisfaction. Revision: Health plans conduct an annual assessment of satisfaction with the UM Process which will include consumer and client satisfaction. For plans subject to NCQA, assessment will also include provider satisfaction. Information may come from surveys, complaints, and/or appeals and produces valid and reliable results. To identify areas of improvement, a quantitative and qualitative analyses is completed. This analysis forms the basis for interventions to improve satisfaction.
	Delegation: Added the policy Performance Management Oversight for Entities that Support Pharmacy Clinical Initiatives
	UM Program: Added: AUMSI makes utilization decisions affecting the health care of members in a fair, impartial and consistent manner.
	UM Program: revised titles of Policies URA 02 UM Processes and Timeframes, URA 03 Notification of UR Determinations, URA 23 Emergency Medical Care, and URA 27 Peer to Peer Conversations to the combined policy URA 02 Utilization Review Process.
VI. Program Authority, Accountability and Committee Structure	Added to the description of Chief Medical Officer that it includes implementation, oversight and evaluation of the UM Program. Revised the name of the QI Program Description, Work Plan, and Evaluation from QI (Quality Improvement) to UM (Utilization Management) documents. Associate Performance: Added: An annual formal appraisal including review of relevant documentation produced by each staff

Topic	Change(s)
	member is completed as explained in URA-20 Annual Staff Assessment Policy.
	Revised the committee structure by deletion of the Commercial/Exchange Quality Improvement Committee (CEQIC).
VII. Program Leadership	Added: The CMO is designated by the President and CEO of AUMSI to oversee the UM Program activities including implementation, oversight and evaluation.
	Added: To definition of Behavioral Health Medical Director: Qualification include: • Must be a physician or have a clinical PhD or PsyD, • May be a medical director, clinical director, participating practitioner from the organization or behavioral healthcare delegate (if applicable).
VIII. Company Programs Supporting UM Program	No changes
IX. Program Documents, Evaluation and Planning	Added: UM Program description includes information sources used to determine benefit coverage and medical necessity and processes.
	Added: AUMSI will also consider members' and client satisfaction, and for plans subject to NCQA will include provider satisfaction. (or use experience) data when evaluating the program.
	Revised the program document titles from QI (Quality Improvement) to UM (Utilization Management) Program Description, Evaluation, and Work Plan.
Appendix A Utilization Management Program Committee Structure	Deleted: The CEQIC (Commercial/Exchange Quality Committee) was deleted from this diagram.
Appendix B Companies Served by Anthem UM Services, Inc.	No changes

Review and Approval of the Utilization Management Program Description by:

AUMSI Quality Improvement Committee — November 21, 2017

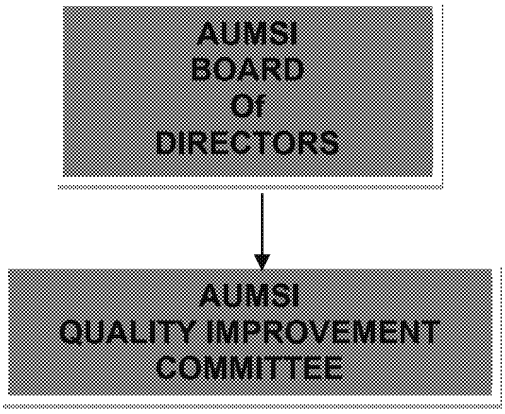
November 21, 2017

Terrence Flannery, M.D. — **Date**

Chief Medical Officer, Anthem UM Services, Inc.

Chairman, AUMSI Quality Improvement Committee

APPENDIX A
AUMSI Committee Structure



APPENDIX B

Companies Served by Anthem UM Services, Inc.

All AUMSI clients are listed herein; however, some of these companies may operate in only a limited number of states. These companies may include, but are not limited to, third party administrators and insurers who may administer self-funded programs.

Anthem Health Plans, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Connecticut) 108 Leigus Road Wallingford, CT 06492	Empire HealthChoice Assurance, Inc.* dba Empire BlueCross Blue Shield (Downstate) & Empire Blue Cross (Upstate) 1 Liberty Plaza New York, NY 10004
Anthem Health Plans of Kentucky, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Kentucky) 13550 Triton Park Blvd. Louisville, KY 40223	Empire HealthChoice HMO, Inc.* dba Empire BlueCross BlueShield HMO (Downstate) & Empire BlueCross HMO (Upstate) 1 Liberty Plaza New York, NY 10004
Anthem Health Plans of Maine, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Maine) 2 Gannett Drive South Portland, ME 04106	HealthLink, Inc. 120 Monument Circle Indianapolis, IN 46204
Anthem Health Plans of New Hampshire, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in New Hampshire) 1155 Elm Street, Suite 200 Manchester, NH 03101	HealthLink HMO, Inc. 1831 Chestnut Street St. Louis, MO 63103
Anthem Health Plans of Virginia, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Virginia) 2015 Staples Mill Road Richmond, VA 23230	Healthy Alliance Life Insurance Company* 1831 Chestnut Street St. Louis, MO 63103
Anthem Insurance Companies, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Indiana) 120 Monument Circle Indianapolis, IN 46204	Healthkeepers, Inc.* 2015 Staples Mill Road Richmond, VA 23230
Anthem Blue Cross Life and Health Insurance Company* 21555 Oxnard Street Woodland Hills, CA 91367	HMO Colorado, Inc. a Colorado Corporation* d/b/a HMO Nevada in Nevada 700 Broadway

	Denver, CO 80273
Blue Cross of California* DBA Anthem Blue Cross 120 S. Via Merida Thousand Oaks, CA 91362	HMO Missouri, Inc.* 1831 Chestnut Street St. Louis, MO 63103
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.* Capital City Plaza 3350 Peachtree Road Atlanta, GA 30326	Matthew Thornton Health Plan, Inc.* 1155 Elm Street, Suite 200 Manchester, NH 03101
Blue Cross & Blue Shield of Georgia* 3350 Peachtree Road Atlanta, GA 30326	Rocky Mountain Hospital and Medical Service, Inc., a Colorado Corporation* d/b/a Anthem Blue Cross Blue Shield (in both Colorado and Nevada) 700 Broadway Denver, CO 80273
Blue Cross Blue Shield of Wisconsin* dba Anthem Blue Cross and Blue Shield N17 W24340 Riverwood Dr. Waukesha, WI 53188	RightCHOICE Managed Care, Inc.* d/b/a RightChoice Benefit Administrators, Inc., Blue Cross Blue Shield of Missouri, Anthem Blue Cross and Blue Shield, Alliance Blue Cross Blue Shield of Missouri and Alliance Blue Cross Blue Shield 1831 Chestnut Street St. Louis, MO 63103
Community Insurance Company* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Ohio) 4361 Irwin Simpson Road Mason, OH 45040	UNICARE Life & Health Insurance Company 233 South Wacker Dr. Chicago, IL 60606
Compcare Health Services Insurance Corporation* dba Anthem Blue Cross and Blue Shield N17 W24340 Riverwood Dr. Waukesha, WI 53188	

*Independent Licensees of the Blue Cross and Blue Shield Association.

Updates/Revisions

Date	Type of Update	
2/27/2018	Added language	Pages 4-5: Added NCQA language regarding what constitutes a case requiring medical necessity review, and that no medical director review is required for benefit denials.

EXHIBIT 11

Anthem UM Services, Inc.

2019

Utilization Management Program Description

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2019
Anthem UM Services, Inc.
Utilization Management Program Description

Anthem, Inc. designates Anthem UM Services, Inc. (AUMSI), a wholly owned subsidiary, to perform utilization management on behalf of the Companies listed on Appendix B. This document refers to these companies collectively as "Company." Throughout this document, unless otherwise specified, "we" refers to AUMSI.

I. MISSION STATEMENT

Anthem UM Services, Inc. (AUMSI) provides a consistent operational, accreditation, regulatory, and quality improvement framework for the provision of utilization management services across the Companies.

II. PURPOSE

This program description outlines how AUMSI oversees quality improvement activities related to utilization management, enables regulatory and accreditation compliance, and promotes operational consistency while maintaining the flexibility to respond to customer needs. These contributions will help to achieve the purpose statement of Anthem, Inc.

Together, we are transforming health care with trusted and caring solutions.

III. GOALS

1. Promote the delivery of medically necessary healthcare services in a cost-effective manner.
2. Perform utilization management services for covered persons in eligible HMO, POS, PPO, EPO, indemnity, Health Insurance marketplace products, commercial group and individual benefit plans and others, as applicable.
3. Promote local coordination of services in collaboration with local business units.
4. Establish, implement, assess and assure that utilization management processes meet the needs of clients and covered persons.
5. Promote quality of service and effective utilization of service to all clients and covered persons.
6. Monitor and improve, where indicated, access to services when relevant to AUMSI's utilization management (UM) activities.
7. Monitor, analyze and report program performance.

8. Develop and maintain a well-integrated, culturally sensitive system to identify, measure, and improve quality outcomes through standardized and collaborative activities.
9. Maintain compliance with accreditation standards and local, state and federal regulatory requirements.
10. Evaluate the effectiveness of the UM Program and the resources dedicated to it specific to UM.

IV. OBJECTIVES

1. Provide covered persons, practitioners, and authorized representatives sufficient access to utilization management programs.
2. Establish and maintain processes to obtain and communicate relevant clinical information in order to make the appropriate determination.
3. Establish a consistent process for providing utilization management determinations in a timely manner to accommodate the clinical urgency of each situation.
4. Provide practitioners and covered persons with sufficient information to understand both the reasons for an adverse determination and how to initiate an appeal.
5. Promote consistency in the use of clinical guidelines to make utilization management and level of care coverage determinations.
6. Establish standards of service and access reflecting current national and competitive benchmarks.
7. Establish monitoring programs to investigate trends and/or patterns of UM services.
8. Design and implement activities to improve program performance.
9. Evaluate the impact of trends on satisfaction.
10. Communicate the results of quality improvement related activities to staff, and the AUMSI QIC or other committees, as appropriate.

V. SCOPE OF UM PROGRAM AND PROGRAM OPERATIONS

Utilization Management is a process used to assess the medical necessity, efficiency, and/or appropriateness of health care services in a fair, impartial and consistent manner. UM evaluates the setting of care, and treatment plans in accordance with the definitions contained in the health benefit plan documents. AUMSI encompasses medical, behavioral health and pharmacy services.

Medical necessity review requires that adverse determinations are made only by an appropriate Peer Clinical Reviewer. Adverse determinations resulting from medical necessity review are within scope of review.

Determinations about the following require medical necessity review:

1. Covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits.
2. Preexisting conditions, when the member has creditable coverage and the organization has a policy to deny preexisting care or services.
3. Care or services whose coverage depends on specific circumstances.

4. Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits.
5. Out-of-network services that are only covered in clinically appropriate situations.
6. Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
7. "Experimental" or "investigational" requests, unless the requested services or procedures are specifically excluded from the benefits plan and deemed never medically necessary under any circumstance in the organization's policies, medical necessity review is not required.

Decisions about the following do not require medical necessity review:

1. Services in the member's benefits plan that are limited by number, duration or frequency.
2. Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
3. Care that does not depend on any circumstances.

Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met in-network (e.g., a service or procedure not provided in-network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards).

If the certificate of coverage or summary of benefits specifies that the organization never covers an out-of-network service for any reason or if the request does not indicate the member has a specific clinical need for which out-of-network coverage may be warranted, the request does not require medical necessity review.

Appropriate practitioners review all medical necessity adverse determinations for requested health care services offered under the Company's medical benefits. No practitioner review is required for requests of medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits.

Behavioral Health Management

Utilization management for behavioral health services follows AUMSI policies and processes for medical necessity review. This includes compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).

Licensed behavioral health professionals manage AUMSI behavioral health functions under the direction of the behavioral health medical director. The medical director provides supervision, oversight and evaluation of the program.

Associates do not perform triage and referral services. These services are not included in the scope of the UM Program.

Pharmacy Management

The Companies' Pharmacy Benefits Manager (PBM) delegate and AUMSI provide pharmacy UM services for the Companies under the direction of the Vice President, Health Care Management. Pharmacy reviewers perform UM services in accordance with policies created in the Pharmacy and Therapeutics (P&T) process.

The Pharmacy and Therapeutics (P&T) process includes two interdependent committees, the P&T committee and the Value Assessment Committee (VAC). The purpose of the P&T process is to make clinically based recommendations that will help promote access to quality medications and, when appropriate, cost effective utilization of benefits. The committees meet quarterly and ad hoc to make determinations regarding the drug formulary. An evaluation of various new and existing products approved by the Food and Drug Administration (FDA) is conducted at the quarterly and ad hoc meetings. Appropriate professionals, including actively practicing physicians and pharmacists, participate in the evaluation. These evaluations result in policies, which identify the appropriate procedures for administering pharmacy benefits related to formulary/edit management. The procedures are reviewed annually and updated as necessary. The review process is supported by pharmacy technicians, registered nurses, pharmacists, and peer clinical reviewers.

The purpose of the P&T is to clinically review drugs for efficacy, safety, effectiveness, and clinical aspects in comparison to similar drugs within a therapeutic class or used to treat a particular condition. The P&T develops and implements the necessary policies and procedures to consistently document how the Clinical Designation was established for efficacy and safety of a drug product. The P&T shall also consider effectiveness data, when available, and Clinical Attributes.

The purpose and function of the VAC is to make recommendations regarding the formulary/tier assignment or formulary/tier edits applied to covered prescription medication (hereinafter referred to as "Tier" or Tiering") in accordance with P&T determinations. For formularies that do not have a tiered copayment structure, drugs are assigned either a formulary or a non-formulary status. There is one Value Assessment Committee for all lines of business that includes Commercial, Medicaid and Medicare business. The VAC considers the Clinical Review Committee's *Clinical Designation* and any *Clinical Comment*(s) before Tier placement is determined.

Prior authorization of benefits (PAB) is required for certain drugs. The goal of this program is to confirm the appropriateness of drug selection to ensure compliance with FDA-approved indications and relevant safety precautions.

Anthem, in collaboration with its PBM delegate and under the direction of the Vice President and Chief Clinical Officer of Pharmacy Services, has programs and processes in place to provide important patient safety information to physicians, covered persons and pharmacists when appropriate. Overseen by Anthem, the Companies' PBM delegate monitors a point of sale drug interactions system that alerts pharmacists of potentially dangerous drug-to-drug interactions that may occur upon dispensing a medication. In addition, the Companies' PBM delegate monitors FDA-required and voluntary drug withdrawals as well as Class I and II recalls that may occur and notifies affected members and prescribers of medication withdrawals and Class I and II drug recalls when due to safety concerns.

A collaborative environment exists between the Pharmacy program and medical and behavioral health providers and programs, supporting AUMSI's ability to identify and act on improvement opportunities. The Pharmacy Program provides quarterly updates to the AUMSI Quality Improvement Committee.

A. Quality Activities for the UM Program

The Program includes monitoring and evaluation of components across UM as well as compliance with regulatory and accreditation requirements. The Program includes activities and analyses conducted by key associates from Utilization Management, Accreditation and Quality Improvement, Grievances and Appeals, Behavioral Health, Pharmacy and Regulatory Compliance.

When opportunities for improvement are identified, the Program implements interventions that are determined to be sufficiently effective in leading to a timely remediation of the issue addressed. Adequate time is provided after implementation to evaluate their effectiveness.

The data sources used for quality improvement measurements may include, but are not limited to, the following:

- UM data
- Complaint and appeal data
- Telephone accessibility data
- Satisfaction survey results related to UM

The UM program includes the following activities:

1. **Confidentiality and Conflict of Interest**
   All AUMSI staff comply with the Corporate Privacy and Ethics Policies and Procedures.

2. **Orientation and Training**
   All AUMSI staff complete orientation and training as described in the AUMSI Orientation and Training Overview. This document is reviewed annually.

3. **Associate Quality Assurance**
   No less than annually, health plans will evaluate the consistency with which peer clinical reviewers and health professionals involved in the utilization management process apply criteria in decision making as explained in Policy URA 14, Inter-rater Reliability Assessments of Clinical Professionals.

4. **Satisfaction with the UM Process**
   Health plans conduct an annual assessment of satisfaction with the UM Process which will include covered persons' and practitioner satisfaction.

   Information may come from surveys, complaints, and/or appeals and produces valid and reliable results. To identify areas of improvement, quantitative and qualitative analyses are completed. This analysis forms the basis for interventions to improve satisfaction.

5. **Compliance with Regulatory and Accreditation Requirements (as applicable)**
   We maintain the state UM licenses that are required to perform utilization review (UR). To enable compliance with applicable laws and regulations, AUMSI maintains a regulatory compliance program.

   The program tracks federal and state UR laws and regulations in the states where we provide UR services. We establish and maintain UR policies and procedures as may be required to enable compliance with applicable laws, regulations, covered persons' contracts, health care provider contracts, and accreditation standards and respond promptly to detected problems and take corrective action as needed. We review policies and procedures as necessary and revise or develop new policies as necessary. Associates will have an opportunity to provide input, as practicable and appropriate, into the policy and procedure development process. The AUMSI Chief Medical Officer issues final approval prior to implementation of policies and procedures.

   We provide support and communicate regulatory and accreditation requirements to UM and other appropriate areas.

6. **Delegation of Utilization Management**
   AUMSI does not have any delegates. If this changes, we would follow Anthem's Delegate/Vendor Oversight and Management Policies and Procedures and Performance Management Oversight for Entities that Support Pharmacy Clinical Initiatives. Both policies set forth the guidelines that associates must follow when performing delegation activities.

B. Utilization Management (UM) Program

The Utilization Management (UM) Program promotes objective systematic ongoing measurement, monitoring and evaluation of services and implementation of quality improvement activities based upon findings.

The scope of the UM Program includes services that are provided by way of telephonic, electronic (e.g. email, Web, and facsimile) and on-site reviews. AUMSI makes utilization management decisions affecting the health care of members in a fair, impartial and consistent manner. Types of reviews performed are prospective, continued stay, and retrospective review, as well as behavioral health management, pharmacy management, appeals and other specialty UM Programs for the following commercial products:

- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
- Point of Service (POS)
- Indemnity
- Health Insurance Marketplace Products,
- Commercial group and individual benefit plans
- Others, as applicable

The Program manages each request appropriately and takes the covered persons' circumstances into consideration. Staff will refer to case and disease management as needed. When making determinations, staff will consider the type of delivery system and membership served.

AUMSI must gather clinical information when determining medical necessity, and documents requests for the necessary clinical information. The data and clinical information used to guide the UM decision-making process should not be burdensome for the member, the practitioner or the health delivery organization's staff, but may include the following sources:

- A history of the presenting problem
- Hospital and office records
- Physical exam results
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psycho-social history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Operative and pathology reports
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information about family members

We request sufficient clinical information to determine if the clinical criteria related to the request have been met.

The Program addresses the following:

1. Clinical review criteria development and new technology evaluation
2. Qualified health professionals
3. Accessibility
4. Timeliness and notification of UM determinations
    - prospective review
    - continued stay review
    - retrospective review
    - predetermination
    - lack of information
    - re-review
    - peer-to-peer conversations
5. Discharge planning
6. On-site review
7. Emergency services
8. Complaint and appeal process

1. **Clinical Review Criteria Development and New Technology Evaluation** Decision criteria applied to utilization review determinations in accordance with the covered person's specific benefit plan may include, but are not limited, to the following:

Criteria Set	Criteria Development Committee
Medical Policy and Clinical UM Guidelines	Medical Policy and Technology Assessment Committee (MPTAC)
MCG	Third Party Criteria Subcommittee (Subcommittee of MPTAC)
Pharmacy Criteria/Prior Authorization Guidelines	Clinical Review Committee (CRC)
Behavioral Health Clinical UM Guidelines	Third Party Criteria Subcommittee (Subcommittee of MPTAC)
AIM Specialty Health Guidelines	Third Party Criteria Subcommittee (Subcommittee of MPTAC)
Applicable state and federal regulatory requirements	State and federal legislatures and regulators.

In some cases, pre-review screen scripts support the application of medical policies and clinical guidelines.

The Medical Policy and Technology Assessment Committee (MPTAC) develop decision criteria for most topics. The principal component of the process is the review for development of medical necessity and investigational policy position statements. MPTAC evaluates selected new medical technologies, procedures and new uses of existing technologies and/or procedures. The technologies include devices, biologics, specialty pharmaceuticals, and behavioral health services. MPTAC also reviews MCG and revises as necessary to be consistent with other policies and guidelines.

The medical policy, ADMIN.00001 Medical Policy Formation, describes the structure and processes of MPTAC. The committee is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. Voting membership includes external physicians in clinical practices and participating in networks, external physicians in academic practices and participating in networks and internal medical directors.

In addition to policies developed or approved through MPTAC, AUMSI medical reviewers use criteria developed by other criteria development committees listed in the table above.

Each criteria development committee reviews all of its criteria at least annually and revises them to develop new criteria as necessary. The criteria are available without charge to providers and covered persons who can request them by contacting their local Anthem UM Department. The AUMSI QIC annually adopts the criteria for AUMSI's use. MPTAC provides timely updates to the AUMSI QIC.

Medical policies are intended to reflect the current scientific data and clinical thinking. While medical policy will set forth position statements for policy development and updating regarding the medical necessity of individual technologies, etc., Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

In the absence of specific medical policy, physician reviewers conduct case-by-case individual reviews. A physician designated by the health plan will review the request using the technology assessment criteria and appropriate standards that may include, but are not limited to, any of the following: peer-reviewed literature, other organizations' technology evaluations including the Blue Cross Blue Shield Association, Agency for Healthcare Research and Quality (AHRQ), various medical specialty societies' guidelines and assessments and the clinician's professional judgement. Refer to the following policy for details: ADMIN.00006 Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guidelines.

2. **Qualified Health Professionals**

Qualified licensed health professionals assess the clinical information used to support UM determinations. When performing utilization management review, health professionals make determinations according to clinical review criteria. Peer clinical reviewers complete all reviews that do not meet medical necessity criteria. Board-certified internal physicians or consultants from appropriate specialty areas conduct appeal reviews. URA-01 Definitions policy further explains the qualifications and tasks.

We do not employ a system for reimbursement, bonuses, or incentives to staff or practitioners based directly on covered person's utilization of health care services.

3. **Accessibility**

Staff are available during and after normal business hours by a toll free telephone number or facsimile to provide communication services to practitioners and covered persons as explained in policy URA-10 Access Standards.

4. **Timeliness and Notification of UR Determinations**

We review relevant clinical information as outlined in URA-02 Utilization Review Process policy, before making a determination. We inform requesting practitioners when we need additional information for a determination (see Lack of Information below). We make determinations within required timeframes and communicate them as explained in policy URA-02 Utilization Review Process.

We make a favorable determination for cases that meet the medical necessity requirements of the health benefit plan.

The following is a brief description of the various UM processes:

Prospective Review
Prospective (pre-service) review is utilization review conducted on a health care service or supply prior to its delivery to the covered person. Medical necessity includes a review of both the service and the setting.

Continued Stay Review
Continued stay review is utilization review conducted during a covered person's ongoing stay in a facility or course of treatment.

Retrospective Review
Retrospective (post-service) review is utilization review conducted after a health care service or supply has been provided to a covered person.

Predetermination
We will provide predetermination medical necessity review at the covered person's or practitioner's request to determine benefit coverage prior to having a service rendered (i.e., in cases where no review is mandated by the UM requirements of the particular plan).

Lack of Information
Some requests for utilization review come in without sufficient pertinent clinical information available to process the request. When this occurs, we may request additional information from the covered person or practitioner as explained in the AUMSI policy, URA-02 Utilization Review Process.

Re-Review
The re-evaluation of an initial UM adverse determination (medical necessity or investigational) by the UM area.

Peer-to-Peer Conversations
Peer clinical reviewers are available for peer-to-peer conversations to discuss impending or issued adverse determinations as explained in policy URA-02 Utilization Review Process.

5. **Discharge Planning**
During discharge planning, we will collaborate and communicate with applicable entities to ensure continuity of care occurs between the acute care facility and other levels of care. In this process, we assess the covered person's plan of care and work with the facilities to arrange and coordinate health services for the covered person. Contract limitations are reviewed, when necessary, to assist with discharge arrangements.

6. **On-Site Review**
Licensed nurses may perform on-site utilization reviews at specific hospitals or other facilities as documented in AUMSI State Specific Addenda.

7. Emergency Services

We will not require prior authorization for emergency medical services as explained in Policy URA-02 Utilization Review Process.

8. Complaint and Appeal Process

We maintain processes to review verbal and written utilization management complaints as documented in Policy URA-13 Complaints UR Process.

We also maintain processes to provide covered persons, practitioners and authorized representatives the right to request a reversal of an adverse determination. Policies URA-04 Appeals Process, and URA-07 External Appeal document these processes.

VI. PROGRAM AUTHORITY, ACCOUNTABILITY AND COMMITTEE STRUCTURE

AUMSI Board of Directors

AUMSI's Board of Directors has designated the AUMSI Quality Improvement Committee (QIC) as responsible for development of the UM Program. The Board reviews and approves the UM Program on an annual basis.

AUMSI Quality Improvement Committee (QIC)

The AUMSI QIC is comprised of predominantly QI and UM leadership from the Companies listed in Appendix B.

Authority and accountability for quality improvement activities and processes is the responsibility of the AUMSI QIC. The Chief Medical Officer (CMO) of AUMSI chairs the committee. The committee serves as a point of interdepartmental integration for quality improvement activities and operations as they relate to AUMSI's UM activities. The committee provides ongoing reporting to the AUMSI Board of Directors and periodically provides reports to the Commercial/Exchange Quality Improvement Committee (CEQIC).

The committee is comprised of members from the following areas:

- Quality and Accreditation
- Regulatory Compliance
- Legal Counsel
- UM
- UM Intake
- Grievances and Appeals
- Designated Medical Directors
- Behavioral Health and the Behavioral Health Medical Director
- Pharmacy

The committee's role includes the following:

- Annually adopts review criteria for AUMSI's use
- Annually reviews and approves the AUMSI UM Program Description, UM Work Plan and UM Annual Evaluation and as revisions occur

- Annually evaluates the effectiveness of the UM Program and monitors progress in meeting performance measures
- Reviews and monitors UM and appeal timeliness results, and other quality indicators
- Provides guidance on initiation of UM-related quality improvement activities
- Approves and monitors UM-related quality improvement activities
- Identifies and provides oversight of appropriate corrective action plans
- Reviews and accepts reports from the relevant committees
- At least annually, considers additions or deletions to the committee roster in order to best represent the UM structure within the Companies
- Monitors reports of delegates' performance, as applicable
- Maintains approved records of all committee meetings

VII. PROGRAM LEADERSHIP

President and Chief Executive Officer, AUMSI

The Board of Directors designates the oversight of UM program activities to the President and Chief Executive Officer (CEO) of AUMSI. The President delegates the day-to-day oversight of and responsibility for the development, implementation and evaluation of the UM Program to the Chief Medical Officer (CMO) of AUMSI.

Chief Medical Officer, AUMSI

The CMO of AUMSI is a senior level physician who is actively involved in implementing and providing guidance to the clinical aspects of AUMSI's UM Program.

The CMO is designated by the President and CEO of AUMSI to oversee the UM Program activities including implementation, oversight and evaluation. The CMO has overall responsibility for the success of the UM Program and is ultimately accountable to ensure that corrective actions and follow-up occurs in pursuit of improvement in medical, behavioral health care, and pharmacy utilization management services. The CMO is responsible for reporting results of UM Program activities to the President and CEO of AUMSI.

Medical Directors

Qualified medical directors provide supervision and guidance to medical directors, consultant physicians, and associates performing UM services. Designated medical directors are members of the AUMSI Quality Improvement Committee and provide input into the UM process. These medical directors ensure that qualified clinicians are accountable to AUMSI for determinations affecting covered persons.

Medical Director, Behavioral Health

The behavioral health medical director is a behavioral health care practitioner who is actively involved in implementing and evaluating the BH aspects of the UM program.
Qualifications include:

- He/she must be a physician or have a clinical PhD or PsyD
- He/she may be a medical director, clinical director, participating practitioner from the organization or behavioral healthcare delegate (if applicable).

Other Departments

Management and associates within AUMSI and the Companies are involved in the design and implementation of quality improvement activities for the UM program. These areas include:

- Quality Improvement
- Medical and behavioral health
- Pharmacy
- Enterprise Clinical Compliance
- Medical Policy
- Legal
- Grievances and Appeals
- Information systems
- Others, as necessary

AUMSI's standing workgroup meetings provide a forum for inter-departmental development, communication, and coordination of the UM quality improvement activities.

VIII. COMPANY PROGRAMS SUPPORTING THE UM PROGRAM

AUMSI is a wholly owned subsidiary of Anthem, and is represented in the Anthem Quality Improvement (QI) Program integration activities. A collaborative environment exists between AUMSI and the Companies as a whole.

Anthem pursues opportunities to integrate and/or develop appropriate corporate-level programs to support collaboration. These programs include the Companies' committees, councils and other bodies. The Anthem QI program responsibilities include national activities and oversight.

IX. PROGRAM DOCUMENTS, EVALUATION and PLANNING

UM Program Description

The UM Program Description is a written description of the UM structure that defines the scope, goals, objectives and planned activities within AUMSI. On an annual basis, AUMSI evaluates the UM Program Description to ensure that the structure, scope, goals, objectives, information sources used to determine benefit coverage and medical necessity, processes and planned activities are current, appropriate and consistent with corporate and business strategic plans. AUMSI will also consider members' and providers' satisfaction (or use experience data when evaluating the program).

The AUMSI QIC provides initial approval of the Program, followed by the AUMSI Board of Directors for final approval.

Utilization Management Work Plan

The AUMSI UM Work Plan serves as an ongoing monitoring and evaluation tool for AUMSI's UM activities. The Program outlines realistic goals, baseline measurements, and time frames as appropriate. On at least an annual basis, AUMSI QIC analyzes reported performance outcomes to assess root causes for variance and barriers to improvement.

On an annual basis, AUMSI evaluates the UM Work plan to determine if current performance measures will continue or AUMSI will prioritize and establish new measures.

The AUMSI QIC provides the approval of the UM Work Plan.

Utilization Management Program Annual Evaluation

The AUMSI Utilization Program Annual Evaluation analyzes key performance measures each year to evaluate current activities and identify new opportunities for improvement. The UM annual evaluation documents assessment of the UM Program goals, effectiveness and scope.

The AUMSI QIC provides the approval of the Annual UM Program Evaluation.

Anthem UM Services, Inc.

Summary of Revisions to the 2019 UM Program Description

Topic	Change(s)
General Changes	The terms "decision" was changed to "determination" The term "denial" was changed to "adverse determination" The term "health care provider" was changed to "practitioner".
I. Mission Statement	No Change
II. Purpose	No Change
III. Goals	Deleted "and expectations" from Goal D
IV. Objectives	Changed "providers" to "practitioners" Added the word management to phrase "utilization determinations Deleted Objective F – Education and Training
V. Scope of Utilization Management Program and Program Operations	• Deleted the term "denial decision" and replaced with "adverse determination" • Deleted term "clinical professional" and replaced with "Peer Clinical Reviewer" • Behavioral Health Management: deleted Triage and Referral • Under Pharmacy: deleted the Clinical Review Committee (CRC) and replaced with Pharmacy and Therapeutics Committee (P&T) • Changed title "Vice President, Clinical and Specialty Pharmacy" to "Vice President and Chief Clinical Officer of Pharmacy Services" • Quality Assurance for UM Program, deleted: ○ Orientation and Training ○ Associate Performance and Quality Assurance ○ Health and Safety of Covered Members
Quality Activities for the UM Program	• Quality Assurance for UM Program, deleted: ○ Orientation and Training ○ Associate Performance and Quality Assurance ○ Health and Safety of Covered Members • Quality Assurance for UM Program, added ○ Inter-Rater Reliability • Confidentiality and Conflict of Interest: deleted prior language and added" All AUMSI staff comply with the Corporate Privacy and Ethics policies" • Orientation and Training: delete prior language and add" All AUMSI staff complete orientation and training as described in the AUMSI Orientation and Training Overview". • Satisfaction with UM Process: deleted term "client" and replaced consumer with term 'covered person" • Compliance with Regulatory and Accreditation Requirements: Changed approval authority for AUMSI policies from QIC to the

	AUMSI Chief Medical Officer. Deleted monthly approval of P&P and replaced with "as necessary". • Delegation of UM: Added "AUMSI does not have any delegates".
UM Program	• Clinical Review Development and New Technology Evaluation: ○ Criteria Development Committees for MCG, Pharmacy Criteria, and AIM: replaced MPTAC with Third Party Criteria Subcommittee ○ Changed statement that MPTAC providers quarterly updated to QIC with stating that MPTAC provides timely updated to AUMSI QIC. • Appropriate Professionals: deleted" Health Professionals, Peer Clinical and Appeal Reviewers support the clinical review process. Under the guidance of a licensed health professional, non-clinical administrative staff may collect non-clinical data or structured clinical data and may approve cases that do not require clinical review." Added: Qualified licensed health professionals assess the clinical information used to support UM determinations. • On Site Review: Deleted reference to AUMSI Policy URA-11. Added reference to AUMSI state-specific addenda. • Emergency Services: deleted the statement that we will render a favorable determination of coverage of Emergency services and added the statement that we will not require prior authorization of emergency services
VI. Program Authority, Accountability and Committee Structure	• Deleted Vendor Management from list of QIC members • Deleted specific reference to complaints and access monitoring and added the phrase "selected quality indicators"
Topic	**Change(s)**
VII. Program Leadership	• Deleted the qualifications for CMO and added "is a senior level physician • Deleted references to the BH Medical Director regarding supervision of staff. • Deleted Credentialing from other departments supporting UM
VIII. Company Programs Supporting UM Program	No change
IX. Program Documents, Evaluation and Planning	No change
Appendix A Utilization Management Program Committee Structure	No change
Appendix B Companies Served by Anthem UM Services, Inc.	Updated the list of companies served by Anthem

Review and Approval of the Utilization Management Program Description by:

AUMSI Quality Improvement Committee

11/27/2018

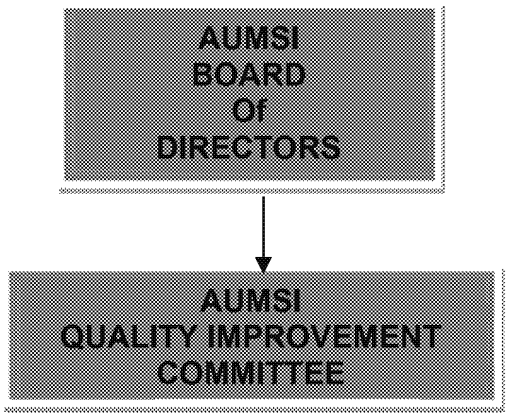
Terrence Flannery, M.D. **Date**

Chief Medical Officer, Anthem UM Services, Inc.

Chairman, AUMSI Quality Improvement Committee

APPENDIX A

AUMSI Committee Structure



APPENDIX B

Companies Served by Anthem UM Services, Inc.

All AUMSI clients are listed herein; however, some of these companies may operate in only a limited number of states. These companies may include, but are not limited to, third party administrators and insurers who may administer self-funded programs.

Anthem Health Plans, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Connecticut) 108 Leigus Road Wallingford, CT 06492	Empire HealthChoice Assurance, Inc.* dba Empire BlueCross Blue Shield (Downstate) & Empire Blue Cross (Upstate) 1 Liberty Plaza New York, NY 10004
Anthem Health Plans of Kentucky, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Kentucky) 13550 Triton Park Blvd. Louisville, KY 40223	Empire HealthChoice HMO, Inc.* dba Empire BlueCross BlueShield HMO (Downstate) & Empire BlueCross HMO (Upstate) 1 Liberty Plaza New York, NY 10004
Anthem Health Plans of Maine, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Maine) 2 Gannett Drive South Portland, ME 04106	HealthLink, Inc. 220 Virginia Avenue Indianapolis, IN 46204
Anthem Health Plans of New Hampshire, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in New Hampshire) 1155 Elm Street, Suite 200 Manchester, NH 03101	HealthLink HMO, Inc. 1831 Chestnut Street St. Louis, MO 63103
Anthem Health Plans of Virginia, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Virginia) 2015 Staples Mill Road Richmond, VA 23230	Healthy Alliance Life Insurance Company* 1831 Chestnut Street St. Louis, MO 63103

Anthem Insurance Companies, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Indiana) 220 Virginia Avenue Indianapolis, IN 46204	Healthkeepers, Inc.* 2015 Staples Mill Road Richmond, VA 23230
Anthem Blue Cross Life and Health Insurance Company* 21555 Oxnard Street Woodland Hills, CA 91367	HMO Colorado, Inc. a Colorado Corporation* d/b/a HMO Nevada in Nevada 700 Broadway Denver, CO 80273
Blue Cross of California* d/b/a Anthem Blue Cross 120 S. Via Merida Thousand Oaks, CA 91362	HMO Missouri, Inc.* 1831 Chestnut Street St. Louis, MO 63103
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.* d/b/a Anthem Blue Cross Blue Shield Capital City Plaza 3350 Peachtree Road Atlanta, GA 30326	Matthew Thornton Health Plan, Inc.* 1155 Elm Street, Suite 200 Manchester, NH 03101
Blue Cross Blue Shield of Wisconsin* d/b/a Anthem Blue Cross and Blue Shield N17 W24340 Riverwood Dr. Waukesha, WI 53188	Rocky Mountain Hospital and Medical Service, Inc., a Colorado Corporation* d/b/a Anthem Blue Cross Blue Shield (in both Colorado and Nevada) 700 Broadway Denver, CO 80273
Community Insurance Company* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Ohio) 4361 Irwin Simpson Road Mason, OH 45040	RightCHOICE Managed Care, Inc.* d/b/a RightChoice Benefit Administrators, Inc., Blue Cross Blue Shield of Missouri, Anthem Blue Cross and Blue Shield, Alliance Blue Cross Blue Shield of Missouri and Alliance Blue Cross Blue Shield 1831 Chestnut Street St. Louis, MO 63103
Compcare Health Services Insurance Corporation* d/b/a Anthem Blue Cross and Blue Shield N17 W24340 Riverwood Dr. Waukesha, WI 53188	UNICARE Life & Health Insurance Company 233 South Wacker Dr. Chicago, IL 60606

Wisconsin Collaborative Insurance Company* N17 W24340 Riverwood Dr. Waukesha, WI 53188	

*Independent Licensees of the Blue Cross and Blue Shield Association

Updates/Revisions

EXHIBIT 12

Anthem UM Services, Inc.

2020

Utilization Management Program Description

TABLE OFCONTENTS

2020
Anthem UM Services, Inc.
Utilization Management Program Description

Anthem, Inc. designates Anthem UM Services, Inc. (AUMSI), a wholly owned subsidiary, to perform utilization management on behalf of the Companies listed on Appendix B. This document refers to these companies collectively as "Company." Throughout this document, unless otherwise specified, "we" refers to AUMSI.

I. MISSION STATEMENT

Anthem UM Services, Inc. (AUMSI) provides a consistent operational, accreditation, regulatory, and quality improvement framework for the provision of utilization management services across the Companies.

II. PURPOSE

This program description outlines how AUMSI oversees quality improvement activities related to utilization management, enables regulatory and accreditation compliance, and promotes operational consistency while maintaining the flexibility to respond to customer needs. These contributions will help to achieve the purpose statement of Anthem, Inc.

Together, we are transforming health care with trusted and caring solutions.

III. GOALS

1. Promote the delivery of medically necessary healthcare services in a cost-effective manner.
2. Perform utilization management services for covered persons in eligible HMO, POS, PPO, EPO, indemnity, Health Insurance marketplace products, commercial group and individual benefit plans and others, as applicable.
3. Promote local coordination of services in collaboration with local business units.
4. Establish, implement, assess and assure that utilization management processes meet the needs of clients and covered persons.
5. Promote quality of service and effective utilization of service to all clients and covered persons.
6. Monitor and improve, where indicated, access to services when relevant to AUMSI's utilization management (UM) activities.
7. Monitor, analyze and report program performance.

8. Develop and maintain a well-integrated, culturally sensitive system to identify, measure, and improve quality outcomes through standardized and collaborative activities.
9. Maintain compliance with accreditation standards and local, state and federal regulatory requirements.
10. Evaluate the effectiveness of the UM Program and the resources dedicated to it specific to UM.

IV. OBJECTIVES

1. Provide covered persons, practitioners, and authorized representatives sufficient access to utilization management programs.
2. Establish and maintain processes to obtain and communicate relevant clinical information in order to make the appropriate determination.
3. Establish a consistent process for providing utilization management determinations in a timely manner to accommodate the clinical urgency of each situation.
4. Provide practitioners and covered persons with sufficient information to understand both the reasons for an adverse determination and how to initiate an appeal.
5. Promote consistency in the use of clinical guidelines to make utilization management and level of care coverage determinations.
6. Establish standards of service and access reflecting current national and competitive benchmarks.
7. Establish monitoring programs to investigate trends and/or patterns of UM services.
8. Design and implement activities to improve program performance.
9. Monitor member and provider experience data to assess satisfaction with the UM program
10. Communicate the results of quality improvement related activities to staff, and the AUMSI QIC or other committees, as appropriate.

V. SCOPE OF UM PROGRAM AND PROGRAM OPERATIONS

Utilization Management is a process used to assess the medical necessity, efficiency, and/or appropriateness of health care services in a fair, impartial and consistent manner. UM evaluates the setting level of care and treatment plans in accordance with the definitions contained in the health benefit plan documents. AUMSI encompasses medical, behavioral health and pharmacy services.

Medical necessity review requires that adverse determinations are made only by an appropriate Peer Clinical Reviewer. Adverse determinations resulting from medical necessity review are within the scope of review.

Determinations about the following require medical necessity review:

1. Covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits.
2. Preexisting conditions, when the member has creditable coverage and the organization has a policy to deny preexisting care or services.

3. Care or services where coverage depends on specific circumstances.
4. Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits.
5. Out-of-network services that are only covered in clinically appropriate situations.
6. Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
7. "Experimental" or "investigational" requests, unless the requested services or procedures are specifically excluded from the benefits plan and deemed never medically necessary under any circumstance in the organization's policies, medical necessity review is not required.

Determinations about the following do not require medical necessity review:

1. Services in the member's benefits plan that are limited by number, duration or frequency.
2. Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
3. Care that does not depend on any circumstances.
4. Requests for personal care services, such as cooking, grooming, transportation, cleaning, and assistance with other activities of daily living (ADL)

Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met in-network (e.g., a service or procedure not provided in-network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards).

If the certificate of coverage or summary of benefits specifies that the organization never covers an out-of-network service for any reason or if the request does not indicate the member has a specific clinical need for which out-of-network coverage may be warranted, the request does not require medical necessity review.

Appropriate practitioners review all medical necessity adverse determinations for requested health care services offered under the Company's medical benefits. No practitioner review is required for requests of medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits.

Behavioral Health Management

Utilization management for behavioral health services follows AUMSI policies and processes for medical necessity review. This includes compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).

Licensed behavioral health professionals manage AUMSI behavioral health functions under the direction of the behavioral health medical director. The medical director provides supervision, oversight and evaluation of the program.

Associates do not perform triage and referral services. These services are not included in the scope of the UM Program.

Pharmacy Management

The Companies' Pharmacy Benefits Manager (PBM) delegate and AUMSI provide pharmacy UM services for the Companies under the direction of the Vice President, Health Care Management. Pharmacy reviewers perform UM services in accordance with policies created in the Pharmacy and Therapeutics (P&T) process.

The Pharmacy and Therapeutics process includes two interdependent committees, the P&T and the Value Assessment Committee (VAC). The purpose of the P&T process is to make clinically based recommendations that will help promote access to quality medications and, when appropriate, cost effective utilization of benefits. The committees meet quarterly and ad hoc to make determinations regarding the drug formulary. An evaluation of various new and existing products approved by the Food and Drug Administration (FDA) is conducted at the quarterly and ad hoc meetings. Appropriate professionals, including actively practicing physicians and pharmacists, participate in the evaluation. These evaluations result in policies, which identify the appropriate procedures for administering pharmacy benefits related to formulary/edit management. The procedures are reviewed annually and updated as necessary. The review process is supported by pharmacy technicians, registered nurses, pharmacists, and peer clinical reviewers.

The purpose of the P&T Committee is to clinically review drugs for efficacy, safety, effectiveness, and clinical aspects in comparison to similar drugs within a therapeutic class or used to treat a particular condition. The P&T Committee develops and implements the necessary policies and procedures to consistently document how the Clinical Designation was established for efficacy and safety of a drug product. The P&T Committee shall also consider effectiveness data, when available, and Clinical Attributes.

The purpose and function of the VAC is to make recommendations regarding the formulary/tier assignment or formulary/tier edits applied to covered prescription medication (hereinafter referred to as "Tier" or Tiering") in accordance with P&T Committee determinations. For formularies that do not have a tiered copayment structure, drugs are assigned either a formulary or a non-formulary status. There is one Value Assessment Committee for all lines of business that includes Commercial, Medicaid and Medicare business. The VAC considers the P&T Committee's *Clinical Designation* and any *Clinical Comment*(s) before Tier placement is determined.

Prior authorization of benefits (PAB) is required for certain drugs. The goal of this program is to confirm the appropriateness of drug selection to ensure compliance with FDA-approved indications and relevant safety precautions.

Anthem, in collaboration with its PBM delegate and under the direction of the Vice President and Chief Clinical Officer of Pharmacy Services, has programs and processes in place to provide important patient safety information to physicians, covered persons and pharmacists when appropriate. Overseen by Anthem, the Companies' PBM delegate monitors a point of sale drug interactions system that alerts pharmacists of potentially dangerous drug-to-drug interactions that may occur upon dispensing a medication. In addition, the Companies' PBM delegate monitors FDA-required and voluntary drug

withdrawals as well as Class I and II recalls that may occur and notifies affected members and prescribers of medication withdrawals and Class I and II drug recalls when due to safety concerns.

A collaborative environment exists between the Pharmacy program and medical and behavioral health providers and programs, supporting AUMSI's ability to identify and act on improvement opportunities. The Pharmacy Program provides quarterly updates to the AUMSI Quality Improvement Committee.

A. Quality Activities for the UM Program

The Program includes monitoring and evaluation of components across UM as well as compliance with regulatory and accreditation requirements. The Program includes activities and analyses conducted by key associates from Utilization Management, Accreditation and Quality Improvement, Grievances and Appeals, Behavioral Health, Pharmacy and Regulatory Compliance.

When opportunities for improvement are identified, the Program implements interventions that are determined to be sufficiently effective in leading to a timely remediation of the issue addressed. Adequate time is provided after implementation to evaluate their effectiveness.

The data sources used for quality improvement measurements may include, but are not limited to, the following:

- UM data
- Complaint and appeal data
- Telephone accessibility data
- Satisfaction survey results related to UM

The UM program includes the following activities:

1. **Confidentiality and Conflict of Interest**
   All AUMSI staff comply with the Corporate Privacy and Ethics Policies and Procedures.

2. **Orientation and Training**
   All AUMSI staff complete orientation and training as described in the AUMSI Orientation and Training Overview. This document is reviewed annually.

3. **Associate Quality Assurance**
   No less than annually, health plans will evaluate the consistency with which peer clinical reviewers and health professionals involved in the utilization management process apply criteria in decision making as explained in Policy URA 14, Inter-rater Reliability Assessments of Clinical Professionals.

4. **Satisfaction with the UM Process**
   AUMSI conducts an annual assessment of satisfaction with the UM Process which will include covered persons' and practitioner satisfaction.

Information may come from surveys, complaints, and/or appeals and produces valid and reliable results. To identify areas of improvement, quantitative and qualitative analyses are completed. This analysis forms the basis for interventions to improve satisfaction.

5. **Compliance with Regulatory and Accreditation Requirements (as applicable)**
We maintain the state UM licenses that are required to perform utilization review (UR). To enable compliance with applicable laws and regulations, AUMSI maintains a regulatory compliance program.

The program tracks federal and state UR laws and regulations in the states where we provide UR services. We establish and maintain UR policies and procedures as may be required to enable compliance with applicable laws, regulations, covered persons' contracts, health care provider contracts, and accreditation standards and respond promptly to detected problems and take corrective action as needed. We review policies and procedures as necessary and revise or develop new policies as necessary. Associates will have an opportunity to provide input, as practicable and appropriate, into the policy and procedure development process. The AUMSI Chief Medical Officer issues final approval prior to implementation of policies and procedures.

We provide support and communicate regulatory and accreditation requirements to UM and other appropriate areas.

6. **Delegation of Utilization Management**
AUMSI does not have any delegates. If this changes, we would follow Anthem's Delegate/Vendor Oversight and Management Policies and Procedures and Performance Management Oversight for Entities that Support Pharmacy Clinical Initiatives. Both policies set forth the guidelines that associates must follow when performing delegation activities.

B. Utilization Management (UM) Program

The Utilization Management (UM) Program promotes objective systematic ongoing measurement, monitoring and evaluation of services and implementation of quality improvement activities based upon findings.

The scope of the UM Program includes services that are provided by way of telephonic, electronic (e.g. email, Web, and facsimile) and on-site reviews. AUMSI makes utilization management decisions affecting the health care of members in a fair, impartial and consistent manner. Types of reviews performed are prospective, continued stay, and retrospective review, as well as behavioral health management, pharmacy management, appeals and other specialty UM programs for the following commercial products:

- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
- Point of Service (POS)
- Indemnity
- Health Insurance Marketplace Products,

- Commercial group and individual benefit plans
- Others, as applicable

The Program manages each request appropriately and takes the covered persons' circumstances into consideration. Staff will refer to case and disease management as needed. When making determinations, staff will consider the type of delivery system and membership served.

AUMSI must gather clinical information when determining medical necessity, and documents requests for the necessary clinical information. The data and clinical information used to guide the UM decision-making process should not be burdensome for the member, the practitioner or the health delivery organization's staff, but may include the following sources:

- A history of the presenting problem
- Hospital and office records
- Physical exam results
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psycho-social history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Operative and pathology reports
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information about family members

We request sufficient clinical information to determine if the clinical criteria related to the request have been met.

The Program addresses the following:

1. Clinical review criteria development and new technology evaluation
2. Qualified health professionals
3. Accessibility
4. Timeliness and notification of UM determinations
    - prospective review
    - continued stay review
    - retrospective review
    - predetermination
    - lack of information
    - re-review
    - peer-to-peer conversations
5. Discharge planning
6. On-site review

7. Emergency services
8. Complaint and appeal process
9. Controls for systems specific to UM denial and appeal notification and receipt dates

1. **Clinical Review Criteria Development and New Technology Evaluation** Decision criteria applied to utilization review determinations in accordance with the covered person's specific benefit plan may include, but are not limited, to the following:

Criteria Set	Criteria Development Committee
Medical Policy and Clinical UM Guidelines	Medical Policy and Technology Assessment Committee (MPTAC)
MCG	Third Party Criteria Subcommittee (Subcommittee of MPTAC)
Pharmacy Criteria/Prior Authorization Guidelines	Pharmacy and Therapeutics Committee
Behavioral Health Clinical UM Guidelines	Third Party Criteria Subcommittee (Subcommittee of MPTAC)
AIM Specialty Health Guidelines	Third Party Criteria Subcommittee (Subcommittee of MPTAC)
Applicable state and federal regulatory requirements	State and federal legislatures and regulators.

In some cases, pre-review screen scripts support the application of medical policies and clinical guidelines.

The Medical Policy and Technology Assessment Committee (MPTAC) develop decision criteria for most topics. The principal component of the process is the review for development of medical necessity and investigational policy position statements. MPTAC evaluates selected new medical technologies, procedures and new uses of existing technologies and/or procedures. The technologies include devices, biologics, specialty pharmaceuticals, and behavioral health services. MPTAC also reviews MCG and revises as necessary to be consistent with other policies and guidelines.

The medical policy, ADMIN.00001 Medical Policy Formation, describes the structure and processes of MPTAC. The committee is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. Voting membership includes external physicians in clinical practices and participating in networks, external physicians in academic practices and participating in networks and internal medical directors.

In addition to policies developed or approved through MPTAC, AUMSI medical reviewers use criteria developed by other criteria development committees listed in the table above.

Each criteria development committee reviews all of its criteria at least annually and revises them to develop new criteria as necessary. The criteria are available without charge to providers and

covered persons who can request them by contacting their local Anthem UM Department. The AUMSI QIC annually adopts the criteria for AUMSI's use. MPTAC provides timely updates to the AUMSI QIC.

Medical policies are intended to reflect the current scientific data and clinical thinking. While medical policy will set forth position statements for policy development and updating regarding the medical necessity of individual technologies, etc., Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

In the absence of specific medical policy, physician reviewers conduct case-by-case individual reviews. A physician designated by the health plan will review the request using the technology assessment criteria and appropriate standards that may include, but are not limited to, any of the following: peer-reviewed literature, other organizations' technology evaluations including the Blue Cross Blue Shield Association, Agency for Healthcare Research and Quality (AHRQ), various medical specialty societies' guidelines and assessments and the clinician's professional judgement. Refer to the following policy for details: ADMIN.00006 Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guidelines.

2. **Qualified Health Professionals**

Qualified licensed health professionals assess the clinical information used to support UM determinations. When performing utilization management review, health professionals make determinations according to clinical review criteria. Peer clinical reviewers complete all reviews that do not meet medical necessity criteria. Board-certified internal physicians or consultants from appropriate specialty areas conduct appeal reviews. URA-01 Definitions policy further explains the qualifications and tasks.

We do not employ a system for reimbursement, bonuses, or incentives to covered persons, employees, providers, or practitioners based directly on covered person's utilization of health care services.

3. **Accessibility**

Staff are available during and after normal business hours by a toll free telephone number or facsimile to provide communication services to practitioners and covered persons seeking information about the UM process and authorization of care as explained in policy URA-10 Access Standards.

4. **Timeliness and Notification of UR Determinations**

We review relevant clinical information as outlined in URA-02 Utilization Review Process policy, before making a determination. Medical necessity includes a review of both the service and the setting. We inform the requesting covered person, covered person's authorized representative, and practitioners when we need additional information for a determination (see Lack of Information below). We make determinations within required timeframes and communicate them as explained in policy URA-02 Utilization Review Process.

We make a favorable determination for cases that meet the medical necessity requirements of the health benefit plan.

The following is a brief description of the various UM processes:

Prospective Review
Prospective (pre-service) review is utilization review conducted on a health care service or supply prior to its delivery to the covered person.

Continued Stay Review
Continued stay review is utilization review conducted during a covered person's ongoing stay in a facility or course of treatment.

Retrospective Review
Retrospective (post-service) review is utilization review conducted after a health care service or supply has been provided to a covered person.

Predetermination
We will provide predetermination medical necessity review at the covered person's or practitioner's request to determine benefit coverage prior to having a service rendered (i.e., in cases where no review is mandated by the UM requirements of the particular plan).

Lack of Information
Some requests for utilization review come in without sufficient pertinent clinical information available to process the request. When this occurs, we may request additional information from the covered person, covered person's authorized representative, or practitioner as explained in the AUMSI policy, URA-02 Utilization Review Process.

Re-Review
The re-evaluation of an initial UM adverse determination (medical necessity or investigational) by the UM area.

Peer-to-Peer Conversations
Peer clinical reviewers are available for peer-to-peer conversations to discuss impending or issued adverse determinations as explained in policy URA-02 Utilization Review Process.

5. **Discharge Planning**
During discharge planning, we will collaborate and communicate with applicable entities to ensure continuity of care occurs between the acute care facility and other levels of care. In this process, we assess the covered person's plan of care and work with the facilities to arrange and coordinate health services for the covered person. Contract limitations are reviewed, when necessary, to assist with discharge arrangements.

6. **On-Site Review**
Licensed nurses may perform on-site utilization reviews at specific hospitals or other facilities as documented in AUMSI State Specific Addenda.

7. Emergency Services

We will not require prior authorization for emergency medical services as explained in Policy URA-02 Utilization Review Process.

8. Complaint and Appeal Process

We maintain processes to review verbal and written utilization management complaints as documented in Policy URA-13 Complaints UR Process.

We also maintain processes to provide covered persons, covered persons' authorized representatives, and practitioners the right to request a reversal of an adverse determination. Policies URA-04 Appeals Process, and URA-07 External Appeal document these processes.

VI. PROGRAM AUTHORITY, ACCOUNTABILITY AND COMMITTEE STRUCTURE

AUMSI Board of Directors

AUMSI's Board of Directors has designated the AUMSI Quality Improvement Committee (QIC) as responsible for development of the UM Program. The Board reviews and approves the UM Program on an annual basis.

AUMSI Quality Improvement Committee (QIC)

The AUMSI QIC is comprised of predominantly QI and UM leadership from the Companies listed in Appendix B.

Authority and accountability for quality improvement activities and processes is the responsibility of the AUMSI QIC. The Chief Medical Officer (CMO) of AUMSI chairs the committee. The committee serves as a point of interdepartmental integration for quality improvement activities and operations as they relate to AUMSI's UM activities. The committee provides ongoing reporting to the AUMSI Board of Directors and periodically provides reports to the Commercial/Exchange Quality Improvement Committee (CEQIC).

The committee is comprised of members from the following areas:

- Quality and Accreditation
- Regulatory Compliance
- Legal Counsel
- UM
- UM Intake
- Grievances and Appeals
- Designated Medical Directors
- Behavioral Health and the Behavioral Health Medical Director
- Pharmacy

The committee's role includes the following:

- Annually adopts review criteria for AUMSI's use
- Annually reviews and approves the AUMSI UM Program Description, UM Work Plan and UM Annual Evaluation and revisions as they occur

- Annually evaluates the effectiveness of the UM Program and monitors progress in meeting performance measures
- Reviews and monitors UM and appeal timeliness results, and other quality indicators
- Provides guidance on initiation of UM-related quality improvement activities and monitors the activities? (combine with bullet below)
- Monitors and provides guidance on UM-related quality improvement activities
- Identifies and provides oversight of appropriate corrective action plans
- Reviews and accepts reports from relevant committees
- At least annually, considers additions or deletions to the committee roster in order to best represent the UM structure within the Companies
- Monitors reports of delegates' performance, as applicable
- Maintains approved records of all committee meetings

VII. PROGRAM LEADERSHIP

President and Chief Executive Officer, AUMSI

The Board of Directors designates the oversight of UM program activities to the President and Chief Executive Officer (CEO) of AUMSI. The President delegates the day-to-day oversight of and responsibility for the development, implementation and evaluation of the UM Program to the Chief Medical Officer (CMO) of AUMSI.

Chief Medical Officer, AUMSI

The CMO of AUMSI is a senior level physician who is actively involved in implementing and providing guidance to the clinical aspects of AUMSI's UM Program.

The CMO is designated by the President and CEO of AUMSI to oversee the UM Program activities including implementation, oversight and evaluation. The CMO has overall responsibility for the success of the UM Program and is ultimately accountable to ensure that corrective actions and follow-up occurs in pursuit of improvement in medical, behavioral health care, and pharmacy utilization management services. The CMO is responsible for reporting results of UM Program activities to the President and CEO of AUMSI.

Medical Directors

Qualified medical directors provide supervision and guidance to medical directors, consultant physicians, and staff performing UM services. Designated medical directors are members of the AUMSI Quality Improvement Committee and provide input into the UM process. These medical directors ensure that qualified clinicians are accountable to AUMSI for determinations affecting covered persons.

Medical Director, Behavioral Health

The behavioral health medical director is a behavioral health care practitioner who is actively involved in implementing and evaluating the BH aspects of the UM program.
Qualifications include:

- He/she must be a physician or have a clinical PhD or PsyD

- He/she may be a medical director, clinical director, participating practitioner from the organization or behavioral healthcare delegate (if applicable).

Other Departments

Management and staff within AUMSI and the Companies are involved in the design and implementation of quality improvement activities for the UM program. These areas include:

- Quality Improvement
- Medical and behavioral health
- Pharmacy
- Enterprise Clinical Compliance
- Medical Policy
- Legal
- Grievances and Appeals
- Information systems
- Others, as necessary

AUMSI's Quality Improvement Committee and standing workgroup meetings provide a forum for inter-departmental development, communication, and coordination of the UM quality improvement activities.

VIII. COMPANY PROGRAMS SUPPORTING THE UM PROGRAM

AUMSI is a wholly owned subsidiary of Anthem, and is represented in the Anthem Quality Improvement (QI) Program integration activities. A collaborative environment exists between AUMSI and the Companies as a whole.

Anthem pursues opportunities to integrate and/or develop appropriate corporate-level programs to support collaboration. These programs include the Companies' committees, councils and other bodies. The Anthem QI program responsibilities include national activities and oversight.

IX. PROGRAM DOCUMENTS, EVALUATION and PLANNING

UM Program Description

The UM Program Description is a written description of the UM structure that defines the scope, goals, objectives and planned activities within AUMSI. On an annual basis, AUMSI evaluates the UM Program Description to ensure that the structure, scope, goals, objectives, information sources used to determine benefit coverage and medical necessity, processes and planned activities are current, appropriate and consistent with corporate and business strategic plans. AUMSI will also consider members' and providers' satisfaction (or use experience data when evaluating the program).

The AUMSI QIC provides initial approval of the Program, followed by the AUMSI Board of Directors for final approval.

Utilization Management Work Plan

The AUMSI UM Work Plan serves as an ongoing monitoring and evaluation tool for AUMSI's UM activities. The Program outlines realistic goals, baseline measurements, and time frames as appropriate. On at least an annual basis, AUMSI QIC analyzes reported performance outcomes to assess root causes for variance and barriers to improvement.

On an annual basis, AUMSI evaluates the UM Work plan to determine if current performance measures will continue or AUMSI will prioritize and establish new measures.

The AUMSI QIC provides the approval of the UM Work Plan.

Utilization Management Program Annual Evaluation

The AUMSI Utilization Program Annual Evaluation analyzes key performance measures each year to evaluate current activities and identify new opportunities for improvement. The UM annual evaluation documents assessment of the UM Program structure, goals, effectiveness and scope.

AUMSI considers member and practitioner experience data when evaluating the UM program.

The AUMSI QIC provides the approval of the Annual UM Program Evaluation.

Anthem UM Services, Inc.
Summary of Revisions to the 2020 UM Program Description

Topic	Change(s)
General Changes	Changed references to "associates" to the term "staff"
I. Mission Statement	N/A
II. Purpose	N/A
III. Goals	N/A
IV. Objectives	Changed "monitoring trends with satisfaction" to "Monitor member and provider experience data to assess satisfaction with the UM program" per NCQA UM 1
V. Scope of Utilization Management Program and Program Operations	Added Requests for personal care services, such as cooking, grooming, transportation, cleaning, and assistance with other activities of daily living (ADL)
Quality Activities for the UM Program	Added " seeking information about the UM process and authorization of care" to the Accessibility bullet
UM Program	Added "Controls for systems specific to UM denial and appeal notification and receipt dates"
VI. Program Authority, Accountability and Committee Structure	• Added "AUMSI considers member and practitioner experience data when evaluating the UM program" to the program evaluation description • QIC section: deleted the term "approves" from the sentence "Approves and monitors UM-related quality improvement activities, and combined the remainder of the sentence to the bullet above to read "Monitors and provides guidance on initiation of UM-related quality improvement activities". AUMSI does not formally vote to approve quality improvement activities.
Topic	**Change(s)**
VII. Program Leadership	Other departments: added QIC to the sentence: "AUMSI's Quality Improvement Committee and standing workgroup meetings provide a forum for inter-departmental development,

	communication, and coordination of the UM quality improvement activities.
VIII. Company Programs Supporting UM Program	N/A
IX. Program Documents, Evaluation and Planning	Program evaluation: added the sentence "AUMSI considers member and practitioner experience data when evaluating the UM program."
Appendix A Utilization Management Program Committee Structure	N/A
Appendix B Companies Served by Anthem UM Services, Inc.	Updated AUMSI Client List

Review and Approval of the Utilization Management Program Description by:

AUMSI Quality Improvement Committee

10/29/2019

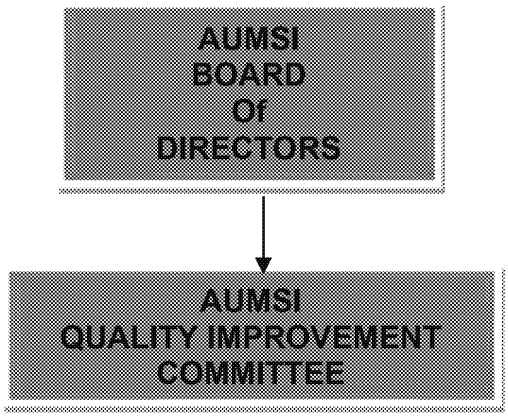
Terrence Flannery, M.D. **Date**

Chief Medical Officer, Anthem UM Services, Inc.

Chairman, AUMSI Quality Improvement Committee

APPENDIX A

AUMSI Committee Structure



APPENDIX B

Companies Served by Anthem UM Services, Inc.

All AUMSI clients are listed herein; however, some of these companies may operate in only a limited number of states. These companies may include, but are not limited to, third party administrators and insurers who may administer self-funded programs.

Anthem Health Plans, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Connecticut) 108 Leigus Road Wallingford, CT 06492	Empire HealthChoice Assurance, Inc.* dba Empire BlueCross Blue Shield (Downstate) & Empire Blue Cross (Upstate) 1 Liberty Plaza New York, NY 10004
Anthem Health Plans of Kentucky, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Kentucky) 13550 Triton Park Blvd. Louisville, KY 40223	Empire HealthChoice HMO, Inc.* dba Empire BlueCross BlueShield HMO (Downstate) & Empire BlueCross HMO (Upstate) 1 Liberty Plaza New York, NY 10004
Anthem Health Plans of Maine, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Maine) 2 Gannett Drive South Portland, ME 04106	HealthLink, Inc. 220 Virginia Avenue Indianapolis, IN 46204
Anthem Health Plans of New Hampshire, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in New Hampshire) 1155 Elm Street, Suite 200 Manchester, NH 03101	HealthLink HMO, Inc. 1831 Chestnut Street St. Louis, MO 63103
Anthem Health Plans of Virginia, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Virginia) 2015 Staples Mill Road Richmond, VA 23230	Healthy Alliance Life Insurance Company* 1831 Chestnut Street St. Louis, MO 63103

Anthem Insurance Companies, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Indiana) 220 Virginia Avenue Indianapolis, IN 46204	Healthkeepers, Inc.* 2015 Staples Mill Road Richmond, VA 23230
Anthem Blue Cross Life and Health Insurance Company* 21555 Oxnard Street Woodland Hills, CA 91367	HMO Colorado, Inc. a Colorado Corporation* d/b/a HMO Nevada in Nevada 700 Broadway Denver, CO 80273
Blue Cross of California* d/b/a Anthem Blue Cross 120 S. Via Merida Thousand Oaks, CA 91362	HMO Missouri, Inc.* 1831 Chestnut Street St. Louis, MO 63103
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.* d/b/a Anthem Blue Cross Blue Shield Capital City Plaza 3350 Peachtree Road Atlanta, GA 30326	Matthew Thornton Health Plan, Inc.* 1155 Elm Street, Suite 200 Manchester, NH 03101
Blue Cross Blue Shield of Wisconsin* d/b/a Anthem Blue Cross and Blue Shield N17 W24340 Riverwood Dr. Waukesha, WI 53188	Rocky Mountain Hospital and Medical Service, Inc., a Colorado Corporation* d/b/a Anthem Blue Cross Blue Shield (in both Colorado and Nevada) 700 Broadway Denver, CO 80273
Community Insurance Company* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Ohio) 4361 Irwin Simpson Road Mason, OH 45040	RightCHOICE Managed Care, Inc.* d/b/a RightChoice Benefit Administrators, Inc., Blue Cross Blue Shield of Missouri, Anthem Blue Cross and Blue Shield, Alliance Blue Cross Blue Shield of Missouri and Alliance Blue Cross Blue Shield 1831 Chestnut Street St. Louis, MO 63103
Compcare Health Services Insurance Corporation* d/b/a Anthem Blue Cross and Blue Shield N17 W24340 Riverwood Dr. Waukesha, WI 53188	UNICARE Life & Health Insurance Company UNICARE Life & Health Insurance Company 220 Virginia Avenue Indianapolis, IN 46204

Wisconsin Collaborative Insurance Company* N17 W24340 Riverwood Dr. Waukesha, WI 53188	

*Independent Licensees of the Blue Cross and Blue Shield Association

Updates/Revisions

EXHIBIT 13

Anthem UM Services, Inc.

2021

Utilization Management Program Description

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2020
Anthem UM Services, Inc.
Utilization Management Program Description

Anthem, Inc. designates Anthem UM Services, Inc. (AUMSI), a wholly owned subsidiary, to perform utilization management on behalf of the Companies listed on Appendix B. This document refers to these companies collectively as "Company." Throughout this document, unless otherwise specified, "we" refers to AUMSI.

I. MISSION STATEMENT

Anthem UM Services, Inc. (AUMSI) provides a consistent operational, accreditation, regulatory and quality improvement framework for the provision of utilization management services across the Companies.

II. PURPOSE

This program description outlines how AUMSI oversees quality improvement activities related to utilization management, enables regulatory and accreditation compliance, and promotes operational consistency while maintaining the flexibility to respond to customer needs. These contributions will help to achieve the purpose statement of Anthem, Inc.

Together, we are transforming health care with trusted and caring solutions.

III. GOALS

1. Promote the delivery of medically necessary healthcare services in a cost-effective manner.
2. Perform utilization management services for covered persons in eligible HMO, POS, PPO, EPO, indemnity, Health Insurance marketplace products, commercial group and individual benefit plans and others as applicable.
3. Promote local coordination of services in collaboration with local business units.
4. Establish, implement, assess and assure that utilization management processes meet the needs of clients and covered persons.
5. Promote quality of service and effective utilization of service to all clients and covered persons.

6. Monitor and improve where indicated, access to services when relevant to AUMSI's utilization management (UM) activities.
7. Monitor, analyze and report program performance.
8. Develop and maintain a well-integrated, culturally sensitive system to identify, measure, and improve quality outcomes through standardized and collaborative activities.
9. Maintain compliance with accreditation standards and local, state and federal regulatory requirements.
10. Evaluate the effectiveness of the UM Program and the resources dedicated to it specific to UM.

IV. OBJECTIVES

1. Provide covered persons, practitioners and authorized representatives sufficient access to utilization management programs.
2. Establish and maintain processes to obtain and communicate relevant clinical information in order to make the appropriate determination.
3. Establish a consistent process for providing utilization management determinations in a timely manner to accommodate the clinical urgency of each situation.
4. Provide practitioners and covered persons with sufficient information to understand both the reasons for an adverse determination and how to initiate an appeal.
5. Promote consistency in the use of clinical guidelines to make utilization management and level of care coverage determinations.
6. Establish standards of service and access reflecting current national and competitive benchmarks.
7. Establish monitoring programs to investigate trends and/or patterns of UM services.
8. Design and implement activities to improve program performance.
9. Monitor member and provider experience data to assess satisfaction with the UM program.
10. Communicate the results of quality improvement related activities to staff and the AUMSI QIC or other committees, as appropriate.

V. SCOPE OF UM PROGRAM AND PROGRAM OPERATIONS

Utilization Management is a process used to assess the medical necessity, efficiency, and/or appropriateness of health care services in a fair, impartial and consistent manner. UM evaluates the setting, level of care and treatment plans in accordance with the definitions contained in the health benefit plan documents. AUMSI encompasses medical, behavioral health and pharmacy services.

Medical necessity review requires that adverse determinations be made only by an appropriate Peer Clinical Reviewer. Adverse determinations resulting from medical necessity review are within the scope of review.

Determinations about the following require medical necessity review:

1. Covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits.
2. Preexisting conditions, when the member has creditable coverage and the organization has a policy to deny preexisting care or services.
3. Care or services where coverage depends on specific circumstances.
4. Dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits.
5. Out-of-network services that are covered only in clinically appropriate situations.
6. Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
7. "Experimental" or "investigational" requests covered by the organization

Determinations about the following do not require medical necessity review:

1. Services in the member's benefits plan that are limited by number, duration or frequency.
2. Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan.
3. Care that does not depend on any circumstances.
4. Requests for personal care services, such as cooking, grooming, transportation, cleaning, and assistance with other activities of daily living (ADL)
5. Experimental" or "investigational" requests that are always excluded and never deemed medically necessary under any circumstance. In these instances, the organization either identifies the specific service or procedure excluded from the benefits plan, or
   If benefits plan materials include broad statements about exclusions but do not specify excluded services or procedures, the materials state that members have the opportunity to request information on excluded services or procedures. The organization maintains internal policies or criteria for these services or procedures.

Requests for coverage of out-of-network services that are covered only when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met in-network (e.g., a service or procedure not provided in-network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards).

If the certificate of coverage or summary of benefits specifies that the organization never covers an out-of-network service for any reason or if the request does not indicate the member has a specific clinical need for which out-of-network coverage may be warranted, the request does not require medical necessity review.

Appropriate practitioners review all medical necessity adverse determinations for requested health care services offered under the Company's medical benefits. No practitioner review is required for requests of medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits.

Behavioral Health Management

Utilization management for behavioral health services follows AUMSI policies and processes for medical necessity review. This includes compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).

Licensed behavioral health professionals manage AUMSI behavioral health functions under the direction of the behavioral health medical director. The medical director provides supervision, oversight and evaluation of the program.

Associates do not perform triage and referral services. These services are not included in the scope of the UM Program.

Pharmacy Management

The Companies' Pharmacy Benefits Manager (PBM) sister company and AUMSI provide pharmacy UM services for the Companies under the direction of the President, IngenioRx. Pharmacy reviewers perform UM services in accordance with policies created in the Pharmacy and Therapeutics (P&T) process.

The Pharmacy and Therapeutics process includes two interdependent committees, the P&T and the Value Assessment Committee (VAC). The purpose of the P&T process is to make clinically based recommendations that will help promote access to quality medications and, when appropriate, cost effective utilization of benefits. The committees meet quarterly and ad hoc to make determinations regarding the drug formulary. An evaluation of various new and existing products approved by the Food and Drug Administration (FDA) is conducted at the quarterly and ad hoc meetings. Appropriate professionals, including actively practicing physicians and pharmacists, participate in the evaluation. These evaluations result in policies, which identify the appropriate procedures for administering pharmacy benefits related to formulary/edit management. The procedures are reviewed annually and updated as necessary. The review process is supported by pharmacy technicians, registered nurses, pharmacists and peer clinical reviewers.

The purpose of the P&T Committee is to clinically review drugs for efficacy, safety, effectiveness and clinical aspects in comparison to similar drugs within a therapeutic class or used to treat a particular condition. The P&T Committee develops and implements the necessary policies and procedures to consistently document how the Clinical Designation was established for efficacy and safety of a drug product. The P&T Committee shall also consider effectiveness data, when available, and Clinical Attributes.

The purpose and function of the VAC is to make recommendations regarding the formulary/tier assignment or formulary/tier edits applied to covered prescription medication (hereinafter referred to as "Tier" or Tiering") in accordance with P&T Committee determinations. For formularies that do not have a tiered copayment structure, drugs are assigned either a formulary or a non-formulary status. There is one Value Assessment Committee for all lines of business that includes Commercial, Medicaid and Medicare business. The VAC considers the P&T Committee's *Clinical Designation* and any *Clinical Comment*(s) before Tier placement is determined.

Prior authorization of benefits (PAB) is required for certain drugs. The goal of this program is to confirm the appropriateness of drug selection to ensure compliance with FDA-approved indications and relevant safety precautions.

Anthem, in collaboration with its PBM sister company and under the direction of the President, IngenioRx, has programs and processes in place to provide important patient safety information to physicians, covered persons and pharmacists when appropriate. Overseen by Anthem, the Companies' PBM sister company monitors a point of sale drug interactions system that alerts pharmacists of potentially dangerous drug-to-drug interactions that may occur upon dispensing a medication. In addition, the Companies' PBM sister company monitors FDA-required and voluntary drug withdrawals as well as Class I and II recalls that may occur and notifies affected members and prescribers of medication withdrawals and Class I and II drug recalls when due to safety concerns.

A collaborative environment exists between the Pharmacy program and medical and behavioral health providers and programs, supporting AUMSI's ability to identify and act on improvement opportunities. The Pharmacy Program provides quarterly updates to the AUMSI Quality Improvement Committee.

A. Quality Activities for the UM Program

The Program includes monitoring and evaluation of components across UM as well as compliance with regulatory and accreditation requirements. The Program includes activities and analyses conducted by key associates from Utilization Management, Accreditation and Quality Improvement, Grievances and Appeals, Behavioral Health, Pharmacy and Regulatory Compliance.

When opportunities for improvement are identified, the Program implements interventions that are determined to be sufficiently effective in leading to a timely remediation of the issue addressed. Adequate time is provided after implementation to evaluate their effectiveness.

The data sources used for quality improvement measurements may include, but are not limited to, the following:

- UM data
- Complaint and appeal data
- Telephone accessibility data
- Satisfaction survey results related to UM

The UM program includes the following activities:

1. **Confidentiality and Conflict of Interest**
   All AUMSI staff comply with the Corporate Privacy and Ethics Policies and Procedures.

2. **Orientation and Training**
   All AUMSI staff complete orientation and training as described in the AUMSI Orientation and Training Overview. This document is reviewed annually.

3. **Associate Quality Assurance**
   No less than annually, health plans will evaluate the consistency with which peer clinical reviewers and health professionals involved in the utilization management process apply criteria in decision making as explained in Policy URA 14, Inter-rater Reliability Assessments of Clinical Professionals.

4. **Satisfaction with the UM Process**
   AUMSI conducts an annual assessment of satisfaction with the UM Process that will include covered persons' and practitioner satisfaction.

   Information may come from surveys, complaints, and/or appeals and produces valid and reliable results. Quantitative and qualitative analyses are completed to identify areas of improvement. This analysis forms the basis for interventions to improve satisfaction.

5. **Compliance with Regulatory and Accreditation Requirements (as applicable)**
   We maintain the state UM licenses that are required to perform utilization review (UR). AUMSI maintains a regulatory compliance program to enable compliance with applicable laws and regulations.

   The program tracks federal and state UR laws and regulations in the states where we provide UR services. We establish and maintain UR policies and procedures as may be required to enable compliance with applicable laws, regulations, covered persons' contracts, health care provider contracts, and accreditation standards and respond promptly to detected problems and take corrective action as needed. We review policies and procedures as necessary and revise or develop new policies as necessary. Associates will have an opportunity to provide input, as practicable and appropriate, into the policy and procedure development process. The AUMSI Chief Medical Officer issues final approval prior to implementation of policies and procedures.

   We provide support and communicate regulatory and accreditation requirements to UM and other appropriate areas.

6. **Delegation of Utilization Management**
   AUMSI does not have any delegates. We would follow Anthem's Delegate/Vendor Oversight and Management Policy if this changes. This sets forth the guidelines that associates must follow when performing delegation activities.

B. Utilization Management (UM) Program

The Utilization Management (UM) Program promotes objective systematic ongoing measurement, monitoring and evaluation of services and implementation of quality improvement activities based upon findings.

The scope of the UM Program includes services that are provided by way of telephonic, electronic (e.g. email, Web, and facsimile) and on-site reviews. AUMSI makes utilization management decisions

affecting the health care of members in a fair, impartial and consistent manner. Types of reviews performed are prospective, continued stay, and retrospective review as well as behavioral health management, pharmacy management, appeals and other specialty UM programs for the following commercial products:

- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
- Point of Service (POS)
- Indemnity
- Health Insurance Marketplace Products,
- Commercial group and individual benefit plans
- Others, as applicable

The Program manages each request appropriately and takes the covered persons' circumstances into consideration. Staff will refer to case and disease management as needed. Staff will consider the type of delivery system and membership served when making determinations.

AUMSI must gather clinical information when determining medical necessity, and documents requests for the necessary clinical information. The data and clinical information used to guide the UM decision-making process should not be burdensome for the member, the practitioner or the health delivery organization's staff but may include the following sources:

- A history of the presenting problem
- Diagnosis codes
- Hospital and office records
- Physical exam results
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psycho-social history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Operative and pathology reports
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from family members

We request sufficient clinical information to determine if the clinical criteria related to the request have been met.

The Program addresses the following:

1. Clinical review criteria development and new technology evaluation
2. Qualified health professionals
3. Accessibility

4. Timeliness and notification of UM determinations
    - prospective review
    - continued stay review
    - retrospective review
    - predetermination
    - lack of information
    - re-review
    - peer-to-peer conversations
5. Discharge planning
6. On-site review
7. Emergency services
8. Complaint and appeal process
9. Controls for systems specific to UM denial and appeal notification and receipt dates

1. **Clinical Review Criteria Development and New Technology Evaluation**

AUMSI has specific criteria to determine the medical necessity and clinical appropriateness of services. Decision criteria applied to utilization review determinations in accordance with the covered person's specific benefit plan may include, but are not limited, to the following:

Criteria Set	Criteria Development Committee
Medical Policy and Clinical UM Guidelines	Medical Policy and Technology Assessment Committee (MPTAC)
MCG	Medical Policy and Technology Assessment Committee (MPTAC)
Pharmacy Criteria/Prior Authorization Guidelines	Pharmacy and Therapeutics Committee
Behavioral Health Clinical UM Guidelines	Medical Policy and Technology Assessment Committee (MPTAC)
AIM Specialty Health Guidelines	Enterprise Quality Oversight Committee
Applicable state and federal regulatory requirements	State and federal legislatures and regulators.

In some cases, pre-review screen scripts support the application of medical policies and clinical guidelines.

The Medical Policy and Technology Assessment Committee (MPTAC) develop decision criteria for most topics. The principal component of the process is the review for development of medical necessity and investigational policy position statements. MPTAC evaluates selected new medical technologies, procedures and new uses of existing technologies and/or procedures. The technologies include devices, biologics, specialty pharmaceuticals, and behavioral health services. MPTAC also reviews MCG and revises as necessary to be consistent with other policies and guidelines.

The medical policy, ADMIN.00001 Medical Policy Formation, describes the structure and processes of MPTAC. The committee is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. Voting membership includes external physicians in clinical practices and participating in networks, external physicians in academic practices and participating in networks and internal medical directors.

In addition to policies developed or approved through MPTAC, AUMSI medical reviewers use criteria developed by other criteria development committees listed in the table above.

Each criteria development committee reviews all of its criteria at least annually and revises them to develop new criteria as necessary. The criteria are available without charge to providers and covered persons who can request them by contacting their local Anthem UM Department. The AUMSI QIC annually adopts the criteria for AUMSI's use. MPTAC provides timely updates to the AUMSI QIC.

Medical policies are intended to reflect the current scientific data and clinical thinking. While medical policy will set forth position statements for policy development and updating regarding the medical necessity of individual technologies, etc., Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

In the absence of specific medical policy, physician reviewers conduct case-by-case individual reviews. A physician designated by the health plan will review the request using the technology assessment criteria and appropriate standards that may include but are not limited to any of the following: peer-reviewed literature, other organizations' technology evaluations including the Blue Cross Blue Shield Association, Agency for Healthcare Research and Quality (AHRQ),various medical specialty societies' guidelines and assessments and the clinician's professional judgement. Refer to the following policy for details: ADMIN.00006 Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline.

2. Qualified Health Professionals

Qualified licensed health professionals assess the clinical information used to support UM determinations. When performing utilization management review, health professionals make determinations according to clinical review criteria. Peer clinical reviewers complete all reviews that do not meet medical necessity criteria. Board-certified internal physicians or consultants from appropriate specialty areas conduct appeal reviews. URA-01 Definitions policy further explains the qualifications and tasks.

Utilization management decisions are based only on medical necessity and appropriateness of care and service, and that the organization does not specifically reward denials of coverage

3. **Accessibility**
Staff are available during and after normal business hours by a toll free telephone number or facsimile to provide communication services to practitioners and covered persons seeking information about the UM process and authorization of care as explained in policy URA-10 Access Standards.

4. **Timeliness and Notification of UR Determinations**
We review relevant clinical information as outlined in URA-02 Utilization Review Process policy, before making a determination. Medical necessity includes a review of both the service and the setting. We inform the requesting covered person or covered person's authorized representative, and practitioners when we need additional information for a determination (see Lack of Information below). We make determinations within required timeframes and communicate them as explained in policy URA-02 Utilization Review Process.

We make a favorable determination for cases that meet the medical necessity requirements of the health benefit plan.

The following is a brief description of the various UM processes:

Prospective Review
Prospective (pre-service) review is utilization review conducted on a health care service or supply prior to its delivery to the covered person.

Continued Stay Review
Continued stay review is utilization review conducted during a covered person's ongoing stay in a facility or course of treatment.

Retrospective Review
Retrospective (post-service) review is utilization review conducted after a health care service or supply has been provided to a covered person.

Predetermination
We will provide predetermination medical necessity review at the covered person's or practitioner's request to determine benefit coverage prior to having a service rendered (i.e., in cases where no review is mandated by the UM requirements of the particular plan).

Lack of Information
Some requests for utilization review come in without sufficient pertinent clinical information available to process the request. When this occurs, we may request additional information from the covered person, covered person's authorized representative, or practitioner as explained in the AUMSI policy, URA-02 Utilization Review Process.

Re-Review
The re-evaluation of an initial UM adverse determination (medical necessity or investigational) by the UM area.

Peer-to-Peer Conversations
Peer clinical reviewers are available for peer-to-peer conversations to discuss impending or issued adverse determinations as explained in AUMSI policy URA-02 Utilization Review Process.

5. **Discharge Planning**
During discharge planning, we will collaborate and communicate with applicable entities to ensure continuity of care occurs between the acute care facility and other levels of care. In this process, we assess the covered person's plan of care and work with the facilities to arrange and coordinate health services for the covered person. Contract limitations are reviewed, when necessary, to assist with discharge arrangements.

6. **On-Site Review**
Licensed nurses may perform on-site utilization reviews at specific hospitals or other facilities as documented in AUMSI State Specific Addenda.

7. **Emergency Services**
We will not require prior authorization for emergency medical services as explained in Policy URA-02 Utilization Review Process.

8. **Complaint and Appeal Process**
We maintain processes to review verbal and written utilization management complaints as documented in Policy URA-13 Complaints UR Process.

We also maintain processes to provide covered persons, covered persons' authorized representatives, and practitioners the right to request a reversal of an adverse determination. AUMSI Policies URA-04 Appeals Process and URA-07 External Appeal document these processes.

9. **Controls of system data specific to UM denial and appeal receipt and notification dates**
We maintain processes to control access to and security of our UM and appeal systems and audit these processes through a quality auditing process.

VI. PROGRAM AUTHORITY, ACCOUNTABILITY AND COMMITTEE STRUCTURE

AUMSI Board of Directors
AUMSI's Board of Directors has designated the AUMSI Quality Improvement Committee (QIC) as responsible for development of the UM Program. The Board reviews and approves the UM Program on an annual basis.

AUMSI Quality Improvement Committee (QIC)
The AUMSI QIC is comprised of predominantly QI and UM leadership from the Companies listed in Appendix B.

Authority and accountability for quality improvement activities and processes is the responsibility of the AUMSI QIC. The Chief Medical Officer (CMO) of AUMSI chairs the committee. The committee

serves as a point of interdepartmental integration for quality improvement activities and operations as they relate to AUMSI's UM activities. The committee provides ongoing reporting to the AUMSI Board of Directors and periodically provides reports to the Commercial/Exchange Quality Improvement Committee (CEQIC).

The committee is comprised of members from the following areas:

- Quality and Accreditation
- Compliance
- Legal Counsel
- UM
- UM Intake
- Grievances and Appeals
- Designated Medical Directors
- Behavioral Health and the Behavioral Health Medical Director
- Pharmacy

The committee's role includes the following:

- Annually adopts review criteria for AUMSI's use
- Annually reviews and approves the AUMSI UM Program Description, UM Work Plan and UM Annual Evaluation and revisions as they occur
- Annually evaluates the effectiveness of the UM Program and monitors progress in meeting performance measures
- Reviews and monitors UM and appeal timeliness results and other quality indicators
- Monitors and provides guidance on initiation of UM-related quality improvement activities and monitors the activities
- Identifies and provides oversight of appropriate corrective action plans
- Reviews and accepts reports from relevant committees
- Considers additions or deletions to the committee roster in order to best represent the UM structure within the Companies at least annually
- Monitors reports of delegates' performance as applicable
- Maintains approved records of all committee meetings

VII. PROGRAM LEADERSHIP

President and Chief Executive Officer, AUMSI

The Board of Directors designates the oversight of UM program activities to the President and Chief Executive Officer (CEO) of AUMSI. The President delegates the day-to-day oversight of and responsibility for the development, implementation and evaluation of the UM Program to the Chief Medical Officer (CMO) of AUMSI.

Chief Medical Officer, AUMSI

The CMO of AUMSI is a senior level physician who is actively involved in implementing and providing guidance to the clinical aspects of AUMSI's UM Program.

The CMO is designated by the President and CEO of AUMSI to oversee the UM Program activities including implementation, oversight and evaluation. The CMO has overall responsibility for the success of the UM Program and is ultimately accountable to ensure that corrective actions and follow-up occurs in pursuit of improvement in medical, behavioral health care, and pharmacy utilization management services. The CMO is responsible for reporting results of UM Program activities to the President and CEO of AUMSI.

Medical Directors

Qualified medical directors provide supervision and guidance to medical directors, consultant physicians, and staff performing UM services. Designated medical directors are members of the AUMSI Quality Improvement Committee and provide input into the UM process. These medical directors ensure that qualified clinicians are accountable to AUMSI for determinations affecting covered persons.

Medical Director, Behavioral Health

The behavioral health medical director is a behavioral health care practitioner who is actively involved in implementing and evaluating the BH aspects of the UM program.
Qualifications include:

- He/she must be a physician or have a clinical PhD or PsyD
- He/she may be a medical director, clinical director, participating practitioner from the organization or behavioral healthcare delegate (if applicable).

Other Departments

Management and staff within AUMSI and the Companies are involved in the design and implementation of quality improvement activities for the UM program. These areas include:

- Quality Improvement
- Medical and behavioral health
- Pharmacy
- Compliance
- Medical Policy
- Legal
- Grievances and Appeals
- Information systems
- Others, as necessary

AUMSI's Quality Improvement Committee and standing workgroup meetings provide a forum for inter-departmental development, communication, and coordination of the UM quality improvement activities.

VIII. COMPANY PROGRAMS SUPPORTING THE UM PROGRAM

AUMSI is a wholly owned subsidiary of Anthem and is represented in the Anthem Quality Improvement (QI) Program integration activities. A collaborative environment exists between AUMSI and the Companies as a whole.

Anthem pursues opportunities to integrate and/or develop appropriate corporate-level programs to support collaboration. These programs include the Companies' committees, councils and other bodies. The Anthem QI program responsibilities include national activities and oversight.

IX. PROGRAM DOCUMENTS, EVALUATION and PLANNING

UM Program Description

The UM Program Description is a written description of the UM structure that defines the scope, goals, objectives and planned activities within AUMSI. On an annual basis AUMSI evaluates the UM Program Description to ensure that the structure, scope, goals, objectives, information sources used to determine benefit coverage and medical necessity, processes and planned activities are current, appropriate and consistent with corporate and business strategic plans. AUMSI will also consider members' and providers' satisfaction (or use experience data when evaluating the program).

The AUMSI QIC provides initial approval of the Program followed by the AUMSI Board of Directors for final approval.

Utilization Management Work Plan

The AUMSI UM Work Plan serves as an ongoing monitoring and evaluation tool for AUMSI's UM activities. The Program outlines realistic goals, baseline measurements, and time frames as appropriate. AUMSI QIC analyzes reported performance outcomes to assess root causes for variance and barriers to improvement on at least an annual basis.

AUMSI evaluates the UM Work plan to determine if current performance measures will continue or AUMSI will prioritize and establish new measures on an annual basis

The AUMSI QIC provides the approval of the UM Work Plan.

Utilization Management Program Annual Evaluation

The AUMSI Utilization Program Annual Evaluation analyzes key performance measures each year to evaluate current activities and identify new opportunities for improvement. The UM annual evaluation documents assessment of the UM Program structure, goals, effectiveness and scope.

AUMSI considers member and practitioner experience data when evaluating the UM program.

The AUMSI QIC provides the approval of the Annual UM Program Evaluation.

Anthem UM Services, Inc.
Summary of Revisions to the 2020 UM Program Description

Topic	Change(s)
General Changes	
I. Mission Statement	
II. Purpose	
III. Goals	
IV. Objectives	
V. Scope of Utilization Management Program and Program Operations	Pg 5 "Determinations about the following require medical necessity review" changed #7 to: "Experimental" or "investigational" requests covered by the organization Pg 5 "Determinations about the following do not require medical necessity review" added: "Experimental" or "investigational" requests that are always excluded and never deemed medically necessary under any circumstance. In these instances, the organization either: Identifies the specific service or procedure excluded from the benefits plan, or If benefits plan materials include broad statements about exclusions but do not specify excluded services or procedures, the materials state that members have the opportunity to request information on excluded services or procedures and the organization maintains internal policies or criteria for these services or procedures. Pg 6: Deleted word "delegate" from the description of AUMSI's PBM, replaced with "sister company". Replaced the title "Vice President Healthcare Management" with "Executive Vice President, IngenioRx and Anthem Healthcare Solutions".
Quality Activities for the UM Program	

UM Program	Pg 9 Added "diagnosis codes" to list of acceptable clinical information Pg 10 Clinical Review Criteria Development: Added the sentence: • AUMSI has specific criteria to determine the medical necessity and clinical appropriateness of services. • Deleted Third Party Criteria Subcommittee and added MPTAC. For AIM: added Enterprise Oversight Committee Pg 12: deleted previous language and revised language to state: Utilization management decisions are based only on appropriateness of care and service and existence of coverage, and that the organization does not specifically reward denials of coverage (note: no material change in intent)
VI. Program Authority, Accountability and Committee Structure	
Topic	
VII. Program Leadership	
VIII. Company Programs Supporting UM Program	
IX. Program Documents, Evaluation and Planning	
Appendix A Utilization Management Program Committee Structure	
Appendix B Companies Served by Anthem UM Services, Inc.	Revised address for: Anthem Blue Cross Life and Health Insurance Company (CA)
Appendix C	Added Appendix C with Louisiana requirements

Review and Approval of the Utilization Management Program Description by:

AUMSI Quality Improvement Committee

11/3/2020

Terrence Flannery, M.D. **Date**

Chief Medical Officer, Anthem UM Services, Inc.

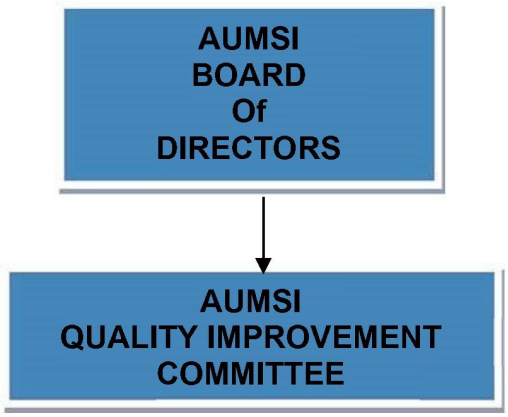
Chairperson, AUMSI Quality Improvement Committee

Revisions

Date	Change
2/2/2021	Deleted reference to coverage and added reference to medical necessity to the following statement on page 11, for consistency with AUMSI Policy URA 21. Utilization management decisions are based only on medical necessity and appropriateness of care and service, and that the organization does not specifically reward denials of coverage
2/2/2021	Changed title to of Pharmacy leadership to President, IngenioRx

APPENDIX A

AUMSI Committee Structure



APPENDIX B

Companies Served by Anthem UM Services, Inc.

All AUMSI clients are listed herein; however, some of these companies may operate in only a limited number of states. These companies may include, but are not limited to, third party administrators and insurers who may administer self-funded programs.

Anthem Health Plans, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Connecticut) 108 Leigus Road Wallingford, CT 06492	Empire HealthChoice Assurance, Inc.* dba Empire BlueCross Blue Shield (Downstate) & Empire Blue Cross (Upstate) 9 Pine Street, 14th Floor New York, NY 10005
Anthem Health Plans of Kentucky, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Kentucky) 13550 Triton Park Blvd. Louisville, KY 40223	Empire HealthChoice HMO, Inc.* dba Empire BlueCross BlueShield HMO (Downstate) & Empire BlueCross HMO (Upstate) 9 Pine Street, 14th Floor New York, NY 10005
Anthem Health Plans of Maine, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Maine) 2 Gannett Drive South Portland, ME 04106	HealthLink, Inc. 220 Virginia Avenue Indianapolis, IN 46204
Anthem Health Plans of New Hampshire, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in New Hampshire) 1155 Elm Street, Suite 200 Manchester, NH 03101	HealthLink HMO, Inc. 1831 Chestnut Street St. Louis, MO 63103
Anthem Health Plans of Virginia, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Virginia) 2015 Staples Mill Road Richmond, VA 23230	Healthy Alliance Life Insurance Company* 1831 Chestnut Street St. Louis, MO 63103

Anthem Insurance Companies, Inc.* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Indiana) 220 Virginia Avenue Indianapolis, IN 46204	Healthkeepers, Inc.* 2015 Staples Mill Road Richmond, VA 23230
Anthem Blue Cross Life and Health Insurance Company* 4453 La Tienda Drive Thousand Oaks, CA 91362	HMO Colorado, Inc. a Colorado Corporation* d/b/a HMO Nevada in Nevada 700 Broadway Denver, CO 80273
Blue Cross of California* d/b/a Anthem Blue Cross 4553 LaTienda Drive Thousand Oaks, CA 91362	HMO Missouri, Inc.* 1831 Chestnut Street St. Louis, MO 63103
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.* d/b/a Anthem Blue Cross Blue Shield Capital City Plaza 3350 Peachtree Road Atlanta, GA 30326	Matthew Thornton Health Plan, Inc.* 1155 Elm Street, Suite 200 Manchester, NH 03101
Blue Cross Blue Shield of Wisconsin* d/b/a Anthem Blue Cross and Blue Shield N17 W24340 Riverwood Dr. Waukesha, WI 53188	Rocky Mountain Hospital and Medical Service, Inc., a Colorado Corporation* d/b/a Anthem Blue Cross Blue Shield (in both Colorado and Nevada) 700 Broadway Denver, CO 80273
Community Insurance Company* d/b/a Anthem Blue Cross and Blue Shield (domiciled in Ohio) 4361 Irwin Simpson Road Mason, OH 45040	RightCHOICE Managed Care, Inc.* d/b/a RightChoice Benefit Administrators, Inc., Blue Cross Blue Shield of Missouri, Anthem Blue Cross and Blue Shield, Alliance Blue Cross Blue Shield of Missouri and Alliance Blue Cross Blue Shield 1831 Chestnut Street St. Louis, MO 63103

Compcare Health Services Insurance Corporation* d/b/a Anthem Blue Cross and Blue Shield N17 W24340 Riverwood Dr. Waukesha, WI 53188	UNICARE Life & Health Insurance Company UNICARE Life & Health Insurance Company 220 Virginia Avenue Indianapolis, IN 46204
Wisconsin Collaborative Insurance Company* 777 E. Wisconsin Avenue Milwaukee, WI 53202	

*Independent Licensees of the Blue Cross and Blue Shield Association

Updates/Revisions

Appendix C

Louisiana Requirements: AUMSI UM Program Description

AUMSI does not engage in the practice of medicine or act to impinge upon or encumber the independent medical judgment of treating physicians or health care providers.

EXHIBIT 14

Utilization Management Operational Guideline		
Subject: Benefit Review	**Approval Authority:**	UM Steering Committee
	Approval Date:	11/10/2020
	Effective Date:	10/17/2017
	Reviewed:	11/09/2020
	Revised:	11/09/2020
Product(s): Commercial including National Accounts		

Purpose: To define the process for reviewing UM requests that may be denied based on the member's Plan Design or Evidence of Coverage (EOC).

Guideline: Utilization Management (UM) requests are reviewed to determine if a benefit limitation, exclusion or maximum is applicable. A service cannot be considered a benefit denial, unless it is specifically noted as a benefit limitation, maximum or exclusion in the member's Plan Design or EOC.

- An example of a benefit maximum is a member that exhausts the Skilled Nursing Facility days allowable for their Plan Design or EOC.
- An example of benefit exclusion is a request for In-vitro fertilization (IVF) where the member's Plan Design or EOC specifically excludes (never covers) this service.

Federal and State law take precedence over this guideline and must be considered first in determining member benefits, review process and any mandated letter or appeal and grievance processes.

Exceptions *(these are scenarios that do not fall in the scope of this Operational Guideline)*

- Grandfathering, TOC or COC reviews
- Out of Network reviews
- Alternate Care Reviews
- Benefit Substitution

Definitions:

Benefit review - includes any or all of the following scenarios:

- Excluded from the member's plan design
- Member has exceeded the allowable coverage under the plan design
- Annual benefit maximum has been reached

Intake – a non-clinical front line associate who receives incoming UM requests

Non-Clinical Staff (NCS) – employees or contracted consultants of a health care plan who do not perform clinical assessments or provide callers with clinical advice. They may be responsible for activities such as obtaining Protected Health Information (PHI), providing benefit information, re-directing callers, and providing verbal and voice mail notification of favorable and adverse determinations (including provision of appeal and peer-to-peer conversation rights).

They may not apply clinical judgment or interpretation, accept unstructured clinical information, deviate from established scripts, engage in unscripted clinical dialogue, or ask clinical follow-up questions.

Peer clinical reviewer (PCR) – a physician, nurse practitioner (contingent upon state nurse practice of scope laws), doctorial-level clinical psychologists or certified-addiction specialist, dentist, pharmacist, chiropractic professional, physical therapist professional, or doctoral-level board-certified behavioral analysts as defined by AUMSI policy URA-01 Definitions, and state-specific addenda.

UM associate – either a licensed or unlicensed associate (non-clinical staff) in UM who performs the day-to-day tasks of the Utilization Management functions of the company including intake, application of criteria, referral to PCR, proper documentation in the case and all required notifications. The UM Associate's role also includes organization determinations and documentation of the criteria. This includes PCR, UM Clinician, Post Service Clinical Claims Review (PSCCR) Clinician or NCS.

Health Care Professional (HCP) – a non-PCR health care professional who:

1. Has undergone formal training in a health care field;
2. Holds an associate or higher degree in a health care field, or holds an active professional license or state certificate to practice as a health professional in a state or territory of the United States and with a scope of practice that is relevant to the clinical area(s) addressed in initial review; and
3. Has professional experience in providing direct patient care.
4. For behavioral health, requires a licensed registered nurse or a licensed master's level or higher behavioral health professional (e.g. LCSW, LPC, PhD).
5. For drug utilization review, if required by state law, a pharmacy technician must:
   a. Possess an active professional relevant license in good standing; or
   b. Be adequately trained and:
      i. Be under the supervision of a pharmacist; or
      ii. Are acting within the scope of algorithms. Pharmacy technicians will work within the confines of algorithms, which do not permit independent decision making. Pharmacy technicians have access to a pharmacist when assistance is required with the application of the algorithm.

   "Adequately trained" means that the individual has been part of an extensive training program and/or have extensive experience at a dispensing site.

Procedure:

I. If request includes a **benefit exclusion** for a service that is **never considered for payment under any circumstance**
   A. For **Virginia local business**
      1. Intake sets up a UM case and it is routed to the UM team
      2. The UM team follows the process outlined in section II
   B. For **all other lines of business** besides Virginia local
      1. Intake advises requestor that this is not a covered service and therefore not eligible for a precertification or predetermination review
      2. Intake directs requestor to Customer Service if they have additional questions about covered benefits
      3. Customer Service may send applicable benefit review outcome letters
      4. If the UM team receives a benefit exclusion case in error, the UM associate
         a) Advises the requestor that the member does not have the benefit and refers the requestor to Customer Service
         b) Cancels the UM case

II. If request includes a **benefit limitation or maximum** for a service that is **never considered for payment under any circumstance**
   A. Intake sets up a UM case and it is routed to the UM team
   B. UM associate reviews the member's Plan Design or EOC

C. UM associate follows unit specific process for mandatory peer clinical reviewer (PCR) referral, as applicable
D. UM associate denies the request, documents the decision and applicable benefit limitation or maximum in the UM case
   1. This decision is a benefit decision and a benefit denial letter is sent on plan letterhead
   2. Completes applicable required notification(s)

III. If request includes a benefit that is covered in specific situations, and a **clinical review is not applicable**, for example, a Plan Design or EOC requirement that care be rendered at a Blue Distinction designated facility
A. Intake sets up a UM case and it is routed to the UM team
B. UM associate reviews the member's Plan Design or EOC
C. UM associate determines if request meets the contractual requirement
D. HCP follows unit specific process for mandatory PCR referral, as applicable
E. If request meets contractual requirement, the UM associate
   1. Completes approval summary in the UM case and includes applicable benefit language
   2. Approves the request
      a) This decision is a benefit decision and the appropriate approval letter is sent on plan letterhead
      b) Completes applicable required notification(s)
F. If request does not meet contractual requirement, the UM associate
   1. Completes denial summary in the UM case and includes applicable benefit language
   2. Denies the request
      a) This decision is a benefit decision and a benefit denial letter is sent on plan letterhead
      b) Completes applicable required notification(s)

IV. If requested service is **covered in specific situations**, and there is **applicable clinical criteria**
A. Intake sets up a UM case and it is routed to the UM team
B. UM clinician (HCP) reviews the member's plan design or EOC and applicable clinical criteria
C. HCP follows unit specific process for mandatory PCR referrals, as applicable
D. If request meets clinical criteria
   1. HCP completes approval summary in the UM case and includes clinical criteria and any applicable benefit language
   2. HCP approves the request
      a) This decision is a medical necessity decision and an AUMSI medical necessity letter is sent
      b) UM associate completes applicable required notification(s)
E. If request does not meet clinical criteria
   1. HCP summarizes the review in the UM case and includes clinical criteria and any applicable benefit language
   2. HCP refers case to PCR
   3. PCR completes review of request, documents decision in UM case and returns the case to the appropriate UM queue or team
   4. UM associate completes the case according to the PCR decision
      a) This decision is a medical necessity decision and an AUMSI medical necessity letter is sent
      b) UM associate completes applicable required notification(s)

References:

- AUMSI Same State Addenda
- AUMSI URA-01 Definitions policy
- AUMSI URA 02 Utilization Review
- Federal and State mandate or regulatory requirements
  Member's Plan Design or Evidence of Coverage

Associated Operational Guidelines (OGs): • Out of Network UM Review Operational Guideline • Administrative Exception Process: Grandfathering • Administrative Exception Process: COC and TOC • Administrative Exception Process: Decision Tree
Associated Desktop Processes (DTPs): • Alternate Care G 4.098 (Case Management) • WPCM 031 Benefit Substitution (Case Management)
Associated Quick Reference Guides (QRGs) • No Benefit QRG (UM Intake)

Action	Date	Summary
Date Issued:	10/17/2017	New Operational Guideline
Socialized	10/23/2017	Presented in UM Solutions
Annual Revision	10/17/2018	Annual review. • Approval authority changed to UM Steering Committee • Updated product language • Added definitions for: Intake, NCS, PCR, UM associate and HCP • Removed flow attachment • Added Intake processes throughout the document. • Updated section I, to focus on benefit exclusion requests and included Virginia local processes. • Updated section II, to focus on benefit limitation and maximum requests. • Added whether the outcome letter was a Plan or AUMSI decision throughout the document. • Replaced references for UM staff to UM associate and for Health Professional to HCP
Reviewed	09/16/2019	Annual review: • Changed approval authority • Updated PCR definition per Base Policy URA-01 Added: nurse practitioner (contingent upon state nurse practice of scope laws) • Added Peer clinical reviewer (PCR) AUMSI definition – 'as defined by AUMSI policy URA-01 Definitions, and state-specific addenda' • Removed Individual under UM clinician (HCP) and added 'health care professional' per AUMSI URA 01 definition • Added 'AUMSI URA 02 Utilization Review' in reference section
Reviewed	11/09/2020	Annual review: • Changed approval authority back to UM Steering • Updated Products to include National Accounts • UM Reviewers changed to Health Care Professionals • Updated Peer Clinical Reviewer (PCR) Definition • Wordsmithing